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Study of the Health Needs of Older Women Experiencing Homelessness in the Perth Metropolitan Area

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Declaration of Authorship

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made.

This thesis is the candidate's own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

Human Ethics

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007, updated 2018). The proposed research study received human research ethics approval from The University of Notre Dame Australia Human Research Ethics Committee, Approval Number # EC00418.

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Abstract

Women aged over 50 years represent the most rapidly growing cohort of the Australian homeless population. Despite an increasing awareness of older Australian women being at risk of homelessness, little is known of how their health contributes to, and changes due to their homelessness. Drawing on the principles of the World Health Organisation's social determinants of health, this study sought to investigate the personal life circumstances of older homeless women who live in the Perth metropolitan area, their healthcare needs and to identify any barriers to their accessing healthcare.

The study used a convergent mixed methods approach using quantitative and qualitative methods to collect and analyse the data. Data collection was conducted in three phases. The first consisted of an on-line survey of specialist homelessness service providers to obtain basic information regarding their services to older homeless women and to seek their willingness to act a referral source for women for the study. The second phase comprised a survey and semi structured interview with 22 women. Semi structured interviews consisting of similar questions were also undertaken with representatives from the homeless and healthcare sectors. The third phase consisted of consideration of all the collected data to identify potential actions and strategies that could address the major themes arising from the second phase of the study before utilising a Delphi process with key stakeholders to review the recommendations and prioritise them.

The study highlighted that women experiencing homelessness had complex and inter-related issues that impacted on their health. The nine major themes that emerged from the interview data were categorised as accommodation and safety; financial insecurity; women's experience of trauma and abuse; stigma, shame that led to embarrassment and fear of being judged; the health impact of their perceived inability to fulfil their role as family nurturer; mental health; complex interaction of physical and mental health issues; cost of healthcare service and pharmaceuticals; and the need for ongoing psychosocial and healthcare support once housed.

While provision of suitable long-term housing was seen as fundamental to addressing the health needs of these women, the study findings highlighted the need for greater understanding of the emotional and physical abuse these older women had experienced which continued to affect their mental and physical health even after suitable housing had been found. The Delphi Panel emphasized the need for structural solutions that incorporated intersectoral collaboration across commonwealth and state government funded agencies to provide health, housing and social support services. As such, the outcomes of the study recommend that policies and integrated service models should be developed within a social determinants of health framework through a consultative process that includes older women with lived experience of homelessness.

The outcomes of this research have direct implications for the development of policy, planning and service delivery within this important area.

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I am especially and sincerely indebted to the women who entrusted and shared with me their accounts of their experience of homelessness. I am also very grateful to the many individuals who work tirelessly within the homelessness and homeless healthcare services and gave me their encouragement and assistance from the inception of this study through to its completion. It is through the collective generosity of all these people that the project was made possible.

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Love and thanks to my daughters Katie and Jane for their encouragement and inspiration, and my grandson Kai for encouraging me to keep going. Finally, a special thankyou to my partner Ray for his love and support throughout.

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List of Abbreviations

ABI	Acquired Brain Injury
ABS	Australian Bureau of Statistics
ADHA	Australian Government Department of Health and Ageing
ADH	Australian Government Department of Health
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
ALSWH	Australian Longitudinal Study on Women's Health
AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse cultures
CBD	Central Business District
CEO	Chief Executive Officer
CVA	Cerebral vascular accident
DCPFS	Department Child Protection and Family Support
DV	Domestic and family violence
ED	Emergency Department
Freo Street Doctor	Fremantle mobile street doctor service
FSH	Fiona Stanley Hospital
GP	General Practitioner, General Practice
HREC	Human Research Ethics Committee
HCP	Healthcare providers
HHC	Homeless HealthCare
ICU	Intensive Care Unit
ID	Identification
Lupus	Lupus Erythematosus
NHMRC	National Health and Medical Research Council
NFA	No Fixed Address
NHHA	National Housing and Homeless Agreement
NPAH	National Partnership on Housing
NZ	New Zealand

NOWHHWG	National Older Women's Housing and Homelessness Working Group
PTSD	Post Traumatic Stress Disorder
Qld	Queensland
RPH	Royal Perth Hospital
RFDS	Royal Flying Doctor Service
RUAH	Ruah Community Services Perth
SARC	Sexual Assault Resource Centre
SES	Socioeconomic status
SHS	Specialist Homelessness Services
SHSP	Specialist homelessness service providers
SHED	Specialist Homeless Information Data Base
SHOR	Specialist Homeless Online Reporting
STD	Sexually Transmitted Infection
St Pat's	Saint Patrick's Community Support Centre Fremantle
St Bart's,	Saint Bartholomew's House East Perth
Street Doctor	Mobile GP and health services
Street to Home	Integrated Perth Street to Home Program by specialist homelessness services
TAFE	Technical and Further Education
Tranby	Tranby Day Centre UnitingCare West
UNDA	The University of Notre Dame Australia
UKNHS	United Kingdom National Health Service
Vic	Victoria
WA	Western Australia
WADC	Government of Western Australia Department of Communities
WADH	Government of Western Australia Department of Health
WAAEH	Western Australian Alliance to End Homelessness
WHFS	Women's Health and Family Services
WHO	World Health Organisation

This dissertation is dedicated to the women who so willingly and generously participated in this study.

Thank you for sharing your stories.

Prologue

The inception of this research came about while I was participating in a consultancy project to document the health needs and gaps in health service provision for disadvantaged people in Perth in 2014. During this time, I became aware of the difficulties facing homeless people, particularly older women and the problems they experienced accessing healthcare services. Further discussions with key stakeholders and exploration of published research highlighted the rapidly increasing trend in homeless older women seeking assistance from specialist homelessness services in Australia. However, despite an increased awareness of the growing number of older women becoming homeless, there was limited research literature about the actual health needs of these women and little to no clear guidance on how to best address these needs, especially in the Western Australian context.

Having recently retired from the health system after working in a range of national, statewide and regional policy development and implementation roles, I was aware of the importance of evidence-based research to influence policy and drive service delivery. Aiming to contribute to evidence around the provision of health services for older women experiencing homelessness, I was accepted as a PhD candidate at the University of Notre Dame in 2015. Whilst I had worked extensively in women's and population health, I had not previously focused specifically on the issue of homelessness and thus began my investigations by engaging with many of the homelessness service providers to better understand the services they deliver. I was fortunate to gain their strong support and that of healthcare providers from the outset of this research. Most importantly, my engagement with key stakeholders and their commitment to this research has enabled me to engage with a diverse range of older women living in a range of different circumstances, who generously and willingly shared their stories of their experience of homelessness, and their suggestions for helping other women. These women's personal accounts underpin the findings of this study.

In more recent years, the issue of older women's homelessness has received increased media attention and enhanced public awareness largely due to increase awareness of the number of older women at risk of homelessness growing across Australia.

During my studies, I have been fortunate to participate as a member on the Working and Reference Groups of several national and state projects that have provided me with an opportunity to share insights obtained through this study with others, including:

- Member of the National Older Women's Housing and Homelessness Working Group whose report "Retiring into Poverty - A National Plan for Change: Increasing Housing Security for Older Women" received tri-partisan support at its launch in Parliament House Canberra (Parliament of Australia) in August 2018;

- Member of the WA Reference Group for the Ageing on the Edge Older Persons Homelessness Prevention Project, whose report, "One rent increase from disaster - Older Renters Living on the Edge in Western Australia" was launched by the Minister for Child Protection; Women's Interests; Prevention of Domestic and family violence; Community Services in Parliament House, Perth in August 2019: and

- Member of the Western Australian Women's Health and Wellbeing Policy Working Group, which was launched by the Minister for Health, Government of Western Australia in September 2019.

My participation on these Groups has enabled the findings of this research to influence recommendations for broader systemic policy change across the country.

Chapter 1
Introduction

Older women comprise the fastest emerging group of people experiencing homelessness in Australia (Petersen & Parsell, 2014; Sharam, 2015; National Older Women's Housing and Homelessness Working Group [NOWHHG] 2018). Despite a growing awareness and growing concern about this vulnerable cohort (Australian Human Rights Commission [AHRC], 2019), little is known of how their health contributes to, and changes as a result of being homeless. The key purpose of this study is to inform this knowledge gap by examining the health needs of older women experiencing homelessness in the Perth metropolitan area to determine how they access healthcare services to meet their health needs. As far as can be ascertained, a study of this nature has not been undertaken elsewhere in Australia. This research will contribute an evidence-base that will inform the development of relevant health and homelessness policies and improve healthcare access and delivery.

Homelessness is a growing problem in Australia. People experiencing homelessness are a vulnerable population who have complex social and health related needs. Although homelessness can take many forms and has varied definition, the Australian Bureau of Statistics [ABS], 2012, for the purposes of the Census of Population and Housing, defines homelessness as the lack of one or more elements that represents 'home'. Based on their data, the rate of homelessness in Australia increased by an estimated rate of 14% between the 2011 and 2016 Australian Censuses. Similarly, the homeless population is ageing, with older women comprising the largest growing group amongst homeless people (Pawson, Parsell, Saunders, Hill & Liu, 2018), increasing by 31% from 2011 through to 2016 (Australian Bureau of Statistics [ABS], 2018). Specialist Homelessness Services (SHS), which provide support to Australians at risk of homelessness or are homeless, have also reported significant increases in the number of older persons seeking support from their services. This reflects

the growing problem of older people, particularly women, who are vulnerable to homelessness (Australian Institute of Health and Welfare [AIHW], 2019a, 2019b).

The increasing vulnerability and state of homelessness among older women across Australia may be attributable to a number of significant predisposing complex reasons. This cannot be explained by a single phenomenon but rather due to a range of inter-related factors that have impacted on these women over their lifetimes. These include socio-economic disadvantage, abuse, trauma and mental health concerns, a high cost of living that includes unaffordable rent and reaching retirement or becoming redundant with limited savings and inadequate superannuation. However, a single change in circumstances or catalyst such as the death of a spouse or a health crisis may also trigger a woman to becoming homeless (Freilich, Levine, Travia, & Webb, 2014; AIHW, 2018b).

Homelessness and health are intrinsically linked. Research from Australia and elsewhere demonstrates people experiencing homelessness have a high prevalence of a range of physical and mental health conditions that result in high rates of morbidity (Phipps, Dalton, Maxwell, & Cleary, 2019) and mortality (Aldridge, 2019). Medical and health needs can also contribute to a person becoming and remaining homeless as homeless people are less likely to access primary and preventive healthcare services. They may also leave their health needs unaddressed until they present seriously ill with a medical crisis at hospital Emergency Departments (Moore, Manias, & Gerdtz, 2011; Zaretzky et al., 2013; Fazel, Geddes & Kushel, 2014; Chant et al., 2014; Stafford & Wood, 2017).

As stated, despite a growing awareness of the increasing cohort of older women becoming homeless, there are limited data in the research literature about how their health contributes to and is impacted by their experiencing homelessness, and their health needs. While there have been a number of studies that have focussed on homelessness, many of these reports examine the entire homeless population (Kaleveld, Seivwright, Box & Callis, 2018; Link et al., 1994) or specific sub-groups such as returned servicemen (Rosenheck, Frisman & Chung, 1994), youth (Kipke, Montgomery, Simon & Iverson, 1997) or some specific individual aspect of the homeless population such as drug and alcohol dependence and mental disorders (Fazel, Khosla, Doll, & Geddes, 2008).

Similarly, while many studies have examined the underlying causes and impact of homelessness in women (Simons & Whitbeck, 1991; Cheung & Hwang, 2004), very few focus specifically on older women despite it being known that they are at special risk of becoming homeless and how they receive medical care. Furthermore, there are limited data on how best to frame and guide government policy to address the intersecting health and homelessness issues facing increasing numbers of older women.

1.1 Purpose of the study

The purpose of this research was to investigate the personal life circumstances of older homeless women, their healthcare needs and to identify barriers to accessing healthcare. The results of this research are intended to provide an evidence base used to inform social, housing and health policy, planning and service delivery for this population cohort.

1.2 Research questions

This study sought to investigate the broader research agenda by seeking to address four research questions:

1. What are the living arrangements, self-reported health conditions and healthcare services utilised by the women?
2. What do the women see as their primary/ predominate healthcare needs?
3. What factors influence the women's ability to access healthcare services to improve their health?
4. What actions could be undertaken to help improve the health and wellbeing of older homeless women?

1.3 Methodology

Utilising a sequential mixed methods approach, this study combined information gained from surveys and extensive semi-structured interviews to explore the history of 22 older homeless women, their circumstances, health conditions and use of healthcare and other support services. A unique aspect of this study is that it also sought the views and contextual information from eight

specialist homelessness service providers and seven healthcare providers with experience of working with older homeless women.

The questions in the survey and the face-to-face interviews were informed by models that utilised a social determinants framework (Marmot, 2005; Marmot & Allen, 2014; Silva, Cesse, & Albuquerque, 2014) to ensure a comprehensive set of topics were fully explored. This process was also informed by direct conversations with senior staff from within the specialist homelessness support and healthcare sectors who had experience working with older homeless women.

Key issues identified by statistical analysis of the survey data and qualitative descriptive thematic analysis of the women's responses to the interview were used to identify nine major themes. Input provided by the specialist homeless services providers and healthcare staff were also examined in the formation of a series of actions and strategies that arose from the analysis. These recommendations were then presented to a Panel of experts who all had direct knowledge or experience of homelessness for consideration using a Delphi process.

The Panel helped confirm the major outcomes of the study and set priorities for implementation of the recommended actions and strategies that they believed would best improve the healthcare available to older homeless women living within the Perth metropolitan area.

1.4 Key findings

The study found that a range of social and economic factors contributed to the women's homeless situation that included family breakdown, history of trauma and abuse, and financial insecurity. Over 80% of the women had a personal history of domestic and family violence which both contributed to them becoming homeless and in some cases, their current healthcare needs. Seventy percent of the women reported their current health as fair to very poor and most reported that that their health had not changed much in the past 12 months. The interviews with the women, and the specialist homeless and healthcare providers, highlighted the fact that mental and physical health conditions were exacerbated by age and lack of a stable accommodation. For many, their mental health

condition was both a predisposing factor and an outcome of their homelessness, which added complexity to their healthcare and support needs.

When asked about their perceived main health needs and what factors were important to them attaining good health and a sense of wellbeing, the women overwhelmingly responded that safe and secure accommodation was pivotal to their health and wellbeing. Accommodation was seen as essential and somewhere where they could relax, heal, reconnect and engage with family, store their belongings and their medications. It also removed them from the streets and sleeping rough which exposed them to ongoing physical and sexual abuse and addressed some of the women's feelings of shame of being homeless that could hinder their preparedness to access health and other care services.

While all the women reported having access to GPs for their primary healthcare needs, they also said that their financial situation limited their ability to access services largely due to the lack of bulk-billing GPs, medical specialists, allied health and dental services. Similarly, medication costs and fear of prescribed medications being stolen while living rough restricted their use. Another barrier to access healthcare was expressed by many of the women who described how they were embarrassed, ashamed and fearful of being judged when seeking healthcare due to the stigma around homelessness and mental health. Similar experiences were conveyed by the specialist homeless services and healthcare providers who acknowledged that women's shame and embarrassment, compounded by a lack of staff understanding and poor communication, created barriers to healthcare and heightened their perceptions of feeling unwelcome, judged and stereotyped.

The study concluded that there is the need for provision of safe, affordable, long-term housing with wrap-around social and healthcare support services for women to address their underlying and ongoing trauma and mental health needs to prevent further episodes of homelessness.

An outcome of this study is to recommend that policy and services targeting people experiencing homelessness need to be developed within a systemic and a social determinants of health framework that includes the collaboration and inclusion of older women with lived experience of homelessness.

1.5 Layout of the thesis

This layout of this thesis commences with a literature review (Chapter 2) that identifies the current gaps in knowledge. The majority of the methods used in this study are outlined in Chapter 3 that outlines the three phases that consisted of:

1. Identification of specialist homeless service providers that supported older homeless women to provide insights to the key issues affecting these women and through which the women were ultimately recruited into this study;
2. Description of the processes associated with the development and analysis of the survey and semi-structured interviews that were used to explore the health needs of the women and their experiences in accessing healthcare, and the complementary semi-structured interviews administered to staff working within the homeless support services and healthcare services; and
3. Synthesis of the survey and interview analyses to identify potential activities and strategies that could improve the health of the older homeless women utilising a Delphi Panel process.

Due to the sequential nature of this study, some methodological details have been incorporated into the various result chapters so it can be readily seen how the study process evolved. The findings of study are described in five chapters consisting of:

1. The initial survey of the special homeless service providers (Chapter 4);
2. Results from the women's survey (Chapter 5);
3. Face-to-face interviews (Chapters 6 and 7) with the women and the homelessness sector and healthcare staff; and
4. The development of the recommendation actions/strategies for exploration by the Delphi Panel (Chapter 8).

The thesis concludes with the Discussion, Conclusion and Recommendations in Chapter 9, followed by the references list and appendices.

Chapter 2

Literature Review

This section presents an overview of relevant literature that examines the definitions of homelessness, as well as the prevalence of complex and multiple reasons for homelessness. This study explored the complexities and the interface of homelessness and healthcare as experienced by older women. The literature search was conducted on, Medline, PsycINFO, CINHAL, SCOPUS, Science Direct, Informit Health Collection, including Google and Google Scholar for grey literature, complemented by manual searches of reference lists to provide a breadth of perspectives and a more comprehensive understanding of the phenomenon under study. The search terms and strategy were developed to ensure broad inclusivity. They were informed by literature scoping, MEDLINE medical subject heading terms (Mesh) and subject filters within specific databases. Subject headings and free-text terms were combined to search for population and intervention terms including the following keywords (free-text terms) and MesH Terms: Homeless Persons, Homeless, Homelessness, Housing, Emergency shelter, Social conditions, Poverty, Aged, Aging, Adult, Middle Aged Women, Female. The author independently selected and reviewed all English language literature chronically dating from March 2015 to February 2020. Due to limited amount of academic literature about older homeless women, the literature review also draws heavily on government literature to complement peer reviewed publications as most of the information systems that document homelessness are held by government organisations such as the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS). The review explores the nature and extent of older women's homelessness; the links between homelessness and health, particularly for older homeless women and access to healthcare services for people experiencing homelessness. The latter part of the review examines some frameworks developed to explore healthcare for the homeless and which were used to underpin the research approach for this study. The Chapter concludes with a

summary of older women's homelessness in WA and the potential relevance of this research to the national agenda.

2.1 Defining homelessness

As stated by Chamberlain and Mackenzie in 1992, there is no universal definition of homelessness (Chamberlain & Mackenzie, 1992) and even in Australia today, we have two main different ways by which homelessness is defined and counted. For the purposes of the Census of Population and Housing, the ABS (2012) defines 'homelessness' as the lack of one or more elements that represent 'home'. This is '…when a person who does not have suitable accommodation alternatives, they are considered homeless if their current living arrangement:

- is a dwelling that is inadequate,
- has no tenure, or if their initial tenure is short and not extendable, or
- does not allow them to have control of, or access to space for social relations'.

This definition was used by the ABS in its five-yearly national censuses of 2011 and 2016 to estimate the number of homeless people living in within Australia. However, the ABS acknowledges that using the Census of Population and Housing data in estimating homelessness can only determine if people were homeless or not at one point of time (Census night). People experiencing homelessness may not participate in the Census and even if they do participate, may not want to reveal themselves as homeless or they may be staying in temporary housing on Census night and do not consider themselves homeless. The ABS recognises some groups are under-reported including Aboriginal and Torres Strait Island people, rough sleepers and people staying in supported accommodation for the homeless and works with service providers to maximise the enumeration of these groups on Census night. Finally, recognising the potential estimation problems for some homeless population groups, the ABS notes the need for supplementary data sources for policy, planning and funding of services to better address the needs of people experiencing homelessness (ABS, 2012).

Alternatively, the AIHW, which manages the Specialist Homeless Services Collection as a nation-wide data collection reported by these services of those

who are homeless or at risk of homelessness, considers that ‘a person is homeless if they are living in:

- non-conventional accommodation such as living on the street, sleeping in parks, squatting, staying in cars, living in improvised dwellings; or
- short-term or emergency accommodation such as refuges, crisis shelters, couch surfing, living temporarily with friends and relatives, insecure accommodation on a short-term basis, emergency accommodation arranged by a specialist homelessness agency (for example, in hotels, motels and so forth’. (AIHW 2019a)

The latter definition more closely aligns with the “cultural” definition used by Chamberlain and MacKenzie (1992) who categorised three levels of homelessness as “primary”’ (without conventional accommodation; that is, living without shelter including living on the streets, in parks, derelict buildings and cars), “secondary” (temporary accommodation often referred to as “couch surfing” and may include emergency, transitional or supported accommodation usually for less than 12 weeks) and “tertiary” living without security of tenure (living in boarding houses that do not meet minimum community standards on a medium to long term for a period of 13 weeks or longer). Interestingly, definitions largely based on the first two levels of homelessness were used by the ABS in their 1996, 2001 and 2006 national censuses before changing to their current definition for the 2010 and 2016 census counts.

In Europe and the United States, a time element is included in the definition of homelessness whereby “chronic homelessness” is defined as an episode lasting more than a year, “intermittent homelessness” for someone who cycles in and out of homelessness repeatedly (including those who alternate between housing and institutional care such as prison, hospitals, and treatment programs) and “crisis homelessness” for a person who is homeless once or twice a year or for a short period of time of less than a year after an unexpected crisis such as job loss, divorce or eviction (Belcher & Deforge, 2012; Fazel et al., 2014). Research undertaken in the USA suggests that of the people who become homeless, 20% will become chronically homeless (Caton et al., 2005).

2.2 Prevalence of homelessness

In keeping with statistics from the USA, UK and Canada, the number of homeless people in Australia is reported to be continuing to grow (Crane & Warnes, 2010; AIHW, 2019a).

Based on the 2016 Australian Census, the rate of homelessness in Australia increased by 4.6% compared to the previous five years growing to 116,427 people nationally and representing 50 persons for every 10,000 persons enumerated in the 2016 Census (ABS, 2018). The number of people aged 55 years of older only accounted for 16% of the total Australian homeless population and the majority were males (63%). However, the number of older homeless females grew by 31% between 2011 and 2016 (AIHW, 2019b). Factors such as domestic violence, relationship breakdown, financial difficulty and limited superannuation were attributed to placing older women at risk of homelessness (AIHW, 2018a).

Similarly, Specialist Homelessness Services (SHS), who provide support to Australians who are at risk of homelessness or homeless, assisted 288,800 people of whom 40% (102,094) were homeless during 2017/18 period (AIHW, 2019c). Whilst people aged over 55 years of age who sought support from SHS in 2017/18 accounted for a little under 9%, this number increased by 33% compared to 2013/14 (AIHW, 2019a). Importantly, unlike the Census data, 57% of the people over the age 55 years and older seeking support from SHS were women, reflecting a growing problem of housing insecurity for older people, particularly women.

2.3 Social inequality, homelessness and health

Homelessness instigates poor health but at the same time, is also an outcome of social and economic disadvantage (Rinehart & Borninkhof, 2012; Stafford & Wood, 2017; Zaretzky, Flatau, Clear, Conroy, Burns, & Spicer 2013; McLoughlin & Carey, 2013). The World Health Organisation (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2008) and stresses that the social, economic and cultural conditions in which people grow, live, work and age are the single most

important determinants of their health and form the key concepts of the WHO Social Determinants of Health. The work of Marmot and others (Marmot, 2005; Marmot & Allen, 2014; Silva et al., 2014) have led to an understanding that the social determinants of health significantly contribute to health inequality. Homelessness is also an outcome of underlying structural factors and consequences, particularly social and economic disadvantage (Fazel et al., 2014; Stafford & Wood, 2017; Sharam, 2015; Phipps et al., 2019; AHRC, 2019). .

The links between homelessness and health inequalities are well documented, including shorter life expectancy and higher morbidity (Rinehart & Borninkhof, 2012; Fazel et al., 2014; Stafford & Wood, 2017). The social determinants of health and homelessness are inter-connected, bi-directional and complex. Furthermore, the longer a person is homeless, the worse their health. Stafford and Wood noted in 2017 that homelessness needs to be viewed as "a combined medical and social issue… addressing homelessness is, itself, an important form of healthcare, not a separate 'non-health' issue" (p.7). For example, in a recent review of homelessness, Kaleveld et al (2018) state:

> Homelessness is one of the deepest expressions of social exclusion and extreme poverty in Australian society. At its core, homelessness is a housing issue as it represents the lack of permanent secure housing. However, if we look only through a housing lens, we miss the multi-dimensional nature of homelessness. Homelessness intersects with many other deep social, health and economic issues. Without addressing these issues alongside a housing response, we will not be able to fully address the problem of homelessness (p.1).

While this sentiment may be true for all homeless people, this is particularly pertinent for the older homeless women who represent the most rapidly growing demographic in the homeless population (AIHW, 2018a).

While insufficient income is a significant risk factor for becoming homeless (Zaretzsky et al., 2013), gender is also recognised as a key determinant of women's health and wellbeing (Australian Government Department of Health and Ageing [ADHA], 2010). In this country, older women's diminished socioeconomic status, together with limited affordable housing has meant that they have become

increasingly vulnerable to housing insecurity and homelessness. Older women are more likely to be living in poverty than older men due to a lifetime of discrimination that included unpaid or underpaid work, and comprise the fastest emerging cohort of people experiencing housing stress and homelessness in Australia (Petersen & Parsell, 2014; Sharam, 2015; National Older Women's Housing and Homelessness Working Group [NOWHHG] 2018).

International evidence has identified a range of complex and interactive reasons why people become homeless that encompass financial (unemployment, poverty and lack of affordable housing), social (relationship breakdown, family violence, physical and sexual abuse) and health (mental health concerns, physical health, and substance misuse) related issues (Steen, 2018; McLoughlin & Carey, 2013; Stafford & Wood, 2017; Fitzpatrick, Bramley & Johnsen, 2013). Older age has also been linked to becoming homeless largely through reduced income and declining rates of home ownership (AIHW, 2018a), particularly for older women as a result of their continued and accumulative economic disadvantage (AHRC 2019).

Whilst the causes of homelessness are often seen as being due to individual or broader complex structural and systemic issues, others have proposed an adoption of a "pathways" approach (Clapham, 2003). Building on this framework, Fitzpatrick et al. (2013) identified there are individual "pathways" to homelessness that encompass multiple and complex aspects of people's lives resulting in their experiencing homelessness and that this pathway does not encompass a simple cause and effect linear model. Others have examined pathways to homelessness among older adults and identified that those who first became homeless before the age of 50 have encountered more adverse life experiences (i.e., mental health and substance use problems, imprisonment) and lower attainment of adult milestones (i.e., marriage, full-time employment) compared to individuals with later onset homelessness (Brown et al., 2016). In a comprehensive overview of the causes of homelessness in older people, Crane and Warnes (2001) also reported that men tend to become homeless at all ages, whereas the women were more likely to have become homeless for the first time in later life suggesting either different factors their respective pathways into and out of homelessness.

Domestic and family violence affects a significant proportion of Australian women with one in six Australian women (one in 16 men) reported to experience physical and/or sexual violence from a current or previous cohabiting partner (AIHW 2018c). Not surprisingly, domestic and family violence is the highest reported reason for women leaving their homes and is one the most common and consistent reasons for seeking assistance from Specialist Homelessness Services in Australia (AIHW 2014; AIHW 2018b). Although the majority of were younger aged 18-34, and domestic violence and family violence was one of the major reasons (21%) for older people aged 55 and over seeking assistance from SHS in 2017-18 (AIHW 2019b).

In addition to being a cause of homelessness, domestic and family violence has been shown to have an adverse impact on women's mental and physical health that can persist throughout the remainder of their lives (Loxton, Dolja-Gore, Anderson, & Townsend, 2017a; Robertiello, 2006; Williams & Mickelson, 2004; Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012).

2.4 Homelessness and older women

Older women have been shown to be particularly vulnerable to becoming homeless due to domestic and family violence, financial difficulties and housing insecurity. Those living alone in their fifties and sixties are also susceptible to a health crisis or age discrimination which can place their employment at risk (Petersen & Jones, 2013). Of those older women who become homeless, most have not had prior experience of homelessness (Petersen & Parsell, 2014).

The pathway for women into homelessness appears to differ from men as the two main reasons for women of all ages seeking assistance from specialist homeless services was due to a breakdown in interpersonal relationships (54%) and financial difficulties (40%) whilst the two main reasons for men were financial difficulties (48%) and problems associated with their accommodation (36%) (AIHW, 2014). Like men, women are affected by housing stress and financial difficulties, but in addition, face high rates of domestic and family violence leading to homelessness (Freilich et al., 2014). Women's experience of homelessness also differs from their male counterparts in that they are and more likely to be living with friends or living in their car and less likely to be sleeping

rough. They are also more likely to be living under threat of physical violence in their home. As a result, women's homelessness is more likely to be less visible (Petersen et al., 2014).

As mentioned earlier, there are difficulties utilising the ABS census data to estimate the number of people experiencing homelessness, with data not representing the full extent of the issue due 'hidden' nature of older women's homelessness. Although data from the Specialist Homelessness Services (SHS) show that the number of women accessing their services across Australia exceed those of men (AIHW, 2019c), estimating the actual number of older women experiencing homelessness is difficult as disclosure is problematic. This is due a range of reasons, including stigma, hiding due to fear of assault and not being aware of classifying themselves "homeless" because they utilise informal networks of support, such as "couch surf" staying with friends or sleeping in cars. It is recognised that the statistical counts understate the full extent of the problem of older women experiencing housing crises and homelessness in Australia (Petersen & Parsell, 2014; AHRC 2019).

Following an extensive literature review and interviews with peak bodies and service providers for a national report on preventing homelessness amongst older Australians, Petersen reported that many of the older women in housing crisis were experiencing homelessness for the first time in their lives (Petersen, Parsell, Phillips & White, 2014). These findings were consistent with those of McFerran (2010) and Freilich et al. (2014) who also noted that financial insecurity in later life can be a major issue for women living alone in their fifties and sixties. Many older women who have become homeless have been financially disadvantaged over their entire lifetimes, have limited superannuation, which is compounded by an increasing cost of living and lack of affordable housing. Further, a health crisis or age discrimination could put their jobs at risk and subsequently subject them to experience homelessness. Homelessness is an escalating problem for women who are over 50 who have experienced a relationship breakdown, or may have had substantial periods out of work to care for children or older parents, may have not have worked in the paid workforce, or have traditionally earned much less than their male colleagues or (McFerran, 2010; Freilich et al., 2014; National Older Women's Housing and Homelessness Working Group, 2018).

Drawing on participants of an earlier Melbourne survey (Sharam, 2011) of single Australian women over 40 years of age who did not believe they would own their own homes outright when they retired, Sharam (2015) used focus groups to further gain understanding of this group and found that single midlife women aged 40-65 were vulnerable to housing insecurity with a high potential of homelessness in their old age (over 65). The study also revealed that while these women were likely to have a tertiary education (perceived as a significant means by which they would improve their financial situation), most had entered female dominated, hence poorer paid employment and their financial gains came too late in their lives to accumulate housing equity. Their reduced lifetime earnings and superannuation, together with the increasing labour market flexibility, job insecurity and reduced hours of work had left the women in this study privately renting accommodation, "financially ill prepared" for their retirement and living "in fear of the future" (Sharam, 2015, p. 59).

In another Australian study that interviewed 125 people aged over 50 years who had become homeless during the previous two years, the authors found that compared to the men, a greater proportion of the women were widowed, divorced or separated (84% versus 64%), had not experienced homeless previously (75% versus 55%), had previously lived in a house or apartment (91% versus 66%), suffering from self-reported depression (78% versus 55%). While physical health issues were similar between the sexes, the men were more likely to have alcohol and gambling issues (Rota-Bartelink & Lipmann, 2007).

Adding to their health and social issues, studies have also shown that homeless men and women frequently encounter violence and victimisation on the streets. Assaults amongst older women in marginal housing are also common (Bowpitt, Dwyer, Sundin & Weinstein, 2011; Murray, 2009; Petersen et al., 2014). Bowpitt et al. (2011), drawing on qualitative data generated in a study of multiple exclusion homelessness in the UK, found no difference in the level of violence experienced by men and women living in hostels, but that women felt especially vulnerable in those settings where men were in the majority. The study identified that both men and women rough sleepers experienced the same hardships on the streets and adopted risky survival practices when sleeping rough, with the men more likely to opt to engage in criminal behaviour to secure money for drugs

or use prison as a source of accommodation. Women, meanwhile, turned to sex work as a means of survival, which in turn had its own risks. A recent Australian review found a higher proportion of women sleeping rough reported being they had been victims of crime compared to men sleeping rough. These women also had high levels of need for mental health support as well as high levels of physical health problems (Box, Flatau, Lester, & Callis, 2018). In the US, a study of women with high levels of mental health needs sleeping rough experienced victimisation and needed to be hyper vigilant to avoid assault (Bonugli et al., 2013; Petersen & Parsell, 2014).

2.5 Homelessness and health

The links between homelessness and health inequalities are well documented including higher morbidity (Phipps et al., 2019) and mortality (Aldridge, 2019) rates from largely treatable medical conditions (UK National Health Service [UKNHS], 2010; White & Newman, 2015). A systematic review of critical illness among homeless people identified they were more likely to have increased incidence of psychiatric conditions, substance (drug and/or alcohol) abuse, chronic disease and infectious disorders, and generally have worse outcomes and less access to medical care compared to matched domiciled cohorts (Chant et al., 2014).

From a health perspective, consideration of a definition of homelessness that has a 'time-dimension' seems important, as there are reports that duration of homelessness impacts on health status (Belcher & DeForge, 2012; Belcher, Scholler-Jaquish, Drummond, 1991; Fazel et al., 2014). The longer people are homeless, the greater and more complex their health needs. "Long term homelessness is characterised by 'tri-morbidity' (the combination of mental ill health, physical health, and drug and or alcohol misuse)". (Hewett, Halligan & Boyce, 2012, p. 1).

Homelessness and ill health are both complex and inter-related, whereby a breakdown in physical health can be a catalyst for a person becoming homeless in the first place (Zaretzky et al., 2013). "Homelessness begets ill health; ill health can lead to or lengthen periods of homelessness" (Rinehart & Borninkhof, 2012, p. 1). The inter-relationship between homelessness and ill-health also appears

to be a two-way process with evidence suggesting that ill health can be a catalyst for a person actually becoming homeless (Medcalf & Russell, 2014; Zaretzky et al., 2013) and that the high prevalence of physical and mental health issues amongst the homeless population helps to perpetuate the cycle of homelessness (Zaretzky et al., 2013) with studies showing that 80% of Australia's homeless adults have at least one diagnosed mental health condition (Witte, 2017).

2.6 Health needs of older homeless women

Compared to the homeless population as a whole, there are fewer studies that have investigated the health issues faced by homeless women, and even fewer that have focused on older homeless women. That said, a study of mortality rates amongst homeless women found older homeless women (aged 45-65 years) were only 1-2 times higher than women in the general population across seven cities in Canada (Cheung & Hwang, 2004).

In addition to a range of health conditions that are reflected in the normal female population, studies with homeless women have also identified the importance of women's need to maintain emotional bonds with their families (Gonyea & Melekis, 2017), especially in those who have experienced trauma (Moravac, 2018) and the impact of stigma (Bonugli, Lesser & Escandon, 2013).

In a longitudinal metropolitan study of homeless women in the United Kingdom, women living in refuges, homeless shelters, hostels and couch surfing, the women described how their social support needs changed, highlighting the importance of their need for continued support from specialist services, including health and housing services. Essentially, for these women their becoming homeless led to further feelings of powerlessness and poor self-esteem, and their up-taking or increasing alcohol and drugs as a means of coping. Women in this study also reported that services were fragmented and rarely personalised to their needs (Cameron, Abrahams, Morgan, Williamson & Henry, 2016).

In a qualitative study of middle aged and older homeless women in Los Angeles, designed to explore their perspectives of health needs and challenges, preventive measures, and barriers and facilitators to health care, several health issues emerged. These included the need for health services that included

vision, dental care, pain management, sexual health and comprehensive and holistic care. The women also described challenges of taking medication, controlling their diets to manage their chronic health conditions and their fear of falling (Salem & Ma-Pham, 2015). In a qualitative study to understand the perspectives of homeless service providers working with homeless women, several key issues arose, particularly the need for healthcare and homelessness providers to establish trust in order to develop health promoting and therapeutic relationships and the need for more gender based outreach services for women (Salem, Kwon & Ames, 2018).

Women's experience of domestic and family violence also has implications for older homeless women's health with data from the Australian Longitudinal study on Women's Health (ALSWH) which commenced in 1996. Participants from ALSWH were randomly selected from a representative sample of cohorts of three generations of women born between 1921–1926, 1946-51 and 1973-78 who had participated in the study over the 16 year study period. The study identified that women who had lived with intimate partner violence (violence between former or current partners) were "more likely to report poorer mental health, physical function and general health, and higher levels of bodily pain" (Loxton et al., 2017a, p. 1). Others have also reported the significant negative mental health impact of life-long trauma and ongoing victimisation on homeless women (Padgett, Leibson Hawkins, Abrams & Davis, 2006; Bonugli et al., 2013; David, Rowe, Staeheli & Ponce, 2015).

Women's experience of domestic and family violence has important implications for the provision of healthcare delivery for homeless women, where it has been shown that for those women who have experienced trauma and abuse from men, female health providers and therapists can be particularly therapeutic as they relate to the women and develop bonds to facilitate feelings of safety and trust (David et al., 2015). Women's preference for female healthcare providers, including female nurses, doctors and psychologists for sensitive procedures and psychological counselling is reflected in the literature (Brooks & Phillips, 1996; Moravac, 2018; Wood, Gazey, Vallesi, Cumming & Chapple, 2018). A US study among middle aged and older women experiencing homelessness found that

access to a female healthcare provider enhanced the likelihood of these women accessing healthcare services (Salem & Ma-Pham, 2015).

2.7 Access to health services for people experiencing homelessness

Numerous international studies have demonstrated that the increased prevalence in chronic diseases, psychiatric disorders and drug-related misuse in the homeless population results in higher rates of acute health-care services, including emergency department (ED) visits and inpatient admissions to hospital (UKNHS, 2010; Fazel et al., 2014; Forchuk, Reiss, Mitchell, Ewen & Meier, 2015). The ED is frequently used by homeless people for issues that could more readily and appropriately addressed in a primary healthcare setting (Moore et al., 2011; Davies & Wood, 2018) despite evidence that primary healthcare programs tailored to addressing the specific needs of homeless people can be more effective than standard care in reducing unnecessary hospital admissions for ambulatory patients (Hwang & Burns, 2014; White & Newman, 2015; Rinehart & Borninkhof, 2012).

Studies in England have shown the high use of secondary healthcare whereby homeless people attend emergency departments up to six times as often as the housed population, are admitted up to four times as often and remain in hospital twice as long (UKNHS, 2010; Hewett & Halligan, 2010). These statistics are indicative of homeless people being sicker at the time of hospital presentation most likely due to poorer access to timely primary care and being less likely to be registered with a GP (Medcalf & Russell, 2014). Similar findings were found in a Western Australian study, where users of an accredited street-based mobile health clinic had significantly higher prevalence of multi-morbidity than age-gender matched mainstream patients (Brett et al., 2014).

However, the results from involving the utilisation of healthcare services by homeless people have yielded variable results. For example, in Belgium, where there is a universal healthcare system with active steerage of the homeless into health care, Verlinde et al. (2010) reported that homeless people in Ghent not only had higher rates of emergency and secondary health care, but also were more likely to consult a GP than the rest of the age and gender-matched controls

(Verlinde, Verdée, Van de Walle, Art, De Maeseneer & Willems, 2010). Meanwhile, a case-control study based in Austria showed that homeless people in Vienna were more likely to suffer from chronic diseases and psychiatric disorders than the control group despite having more contact with GPs in the previous 28 days (Wagner, Diehl, Mutsch, Löffler, Burkert, & Freidl, 2014). Following the introduction of the free safety net primary care system for homeless people in Dublin, uptake of prescription medications and self-reported health improved with a corresponding reduction in utilisation of emergency department and out-patient services highlighting the importance of removing real or perceived barriers to healthcare (Keogh, O'Brien, Hoban, O'Carroll, & Fahey, 2015).

2.8 Frameworks to explore healthcare access by the homeless

Clearly, the homeless have significant health concerns. However, their use of healthcare services often occurs more at the crisis stage resulting in use of hospital emergency departments and inpatient admissions rather than primary care and preventive health services (Moore et al., 2011; Wood et al., 2017; Stafford & Wood, 2017).

In a study of the health needs and barriers to healthcare in American women, the authors found the most significant barriers for women in their study were not knowing where to go for healthcare, long waiting times to see a healthcare provider, and being too ill to seek care (Lewis, Andersen & Gelberg, 2003). Others have shown that homeless people, or those at risk of homelessness, find it difficult or are reluctant to access health services for a number of reasons including the need to fulfil competing needs such as food, safety and shelter, accompanied by systemic issues such as lack of access to primary healthcare and a fear of being adversely judged (Campbell, O'Neill, Gibson & Thurston, 2015; Plumb 2000; Rinehart & Borninkhof 2012; Davies & Wood, 2018).

Drawing on this social determinants model of thinking, Aday examined access to primary care services by the homeless to develop his *Equity of Access to Medical Care Framework* (Aday & Andersen, 1981) which subsequently evolved into the *Behavioural Model for Vulnerable Populations* (Gelberg, Andersen, & Leake, 2000). Gelberg's model recognised how the underlying social determinants of health impact on the vulnerable homeless population

including demographic characteristics (age, race/ ethnicity, gender), residential history, social support, psychological trauma, ability to negotiate the system, competing needs, victimisation, access to health services, satisfaction with care and health outcomes (See Appendix W).

Acknowledging that homeless patients' needs are complex, unique and require qualitative inquiry, Kertesz et al. (2014) developed a tool specifically developed to assess the quality of primary healthcare experienced by homeless patients. The *Primary Care Quality-Homeless (PHQ-H) Instrument* incorporates semi- structured questionnaires designed to address and assess patients' experience of primary care. This model recognises that homeless patients have unique and complex needs, and experience challenges in obtaining primary healthcare responsive to their needs. It provides an assessment tool useful for the development of questions to better understand, through qualitative enquiry, perceptions of health care; including client/ clinician relationship, feeling adversely judged, mistrust and satisfaction with services. The tool also provides questions to consider client perceptions of cooperation and collaboration between providers, access to services and the ability to manage their healthcare against competing needs (Kertesz et al., 2013 & 2014).

While there has been a call to develop innovative primary healthcare programs that reflect the environmental and financial conditions of homeless people through appropriate disease and management strategies (Fazel et al., 2014; Hwang & Burns, 2014) and for further research to determine the best models of care for this population to meet their health needs (Fazel et al., 2014; Geddes & Fazel, 2011), the requirement still remains for greater understanding of the gender and age-specific needs of homeless people (Crane & Warnes, 2010; Upshur, Weinreb, Reed, & Frisard, 2015), especially older women (Phipps et al., 2019).

2.9 The Western Australian context

Australian census data shows homelessness in WA was approximately 8% of the national total in 2016 with the rate of homelessness being lower at 36.4 per 10,000 people compared to 49.8 per 10,000 nationally. While the total number of homeless people in WA dropped slightly in 2016 (n=9,005) compared to 2011 (n=9,188), the number of homeless people aged 55 years and over increased marginally from 1,434 to 1,500 between the two census periods (ABS, 2018).

Drawing on the same Census data, a report prepared for the Council of the Ageing WA Inc (COTAWA) and the Ageing on the Edge Older Persons Homelessness Prevention Project by Fiedler and Faulkner (2019) found that in WA, the proportion of people aged 55+ as a percentage of all homeless people was 16.7% compared to 16.0% nationally. The number of older people at risk of homelessness has increased in WA by 46.8% between 2011 and 2016, 61% of whom are women. While the number of WA homeless males aged over 55 years (n=1134) was greater than the number of women (n=876), the percentage change between the 2011 and 2016 Census was 8.9% for males and 20.3% for females (with the largest growth in women aged 75+ (24.3%).

Using data from the Specialist Homeless Services Collection that captures the support provided to people who are homeless or at risk of becoming homeless, the same authors reported a 14% growth in the number of female clients in WA aged 55+ years compared to 8.6% for males of the same age between 2011/12 and 2017/18. For women aged 65+, the growth in client numbers increased by 19.6% compared to 9.3% in similarly aged men (Fiedler & Faulkner, 2019).

Mirroring the data described above, Shelter WA, a peak advocacy body in WA, has also reported that homeless service providers have provided anecdotal evidence about the growing number of older women in WA who are homeless or living in precarious housing situations. Many of these women have not previously sought welfare services; worked throughout their lives and raised children to “now find themselves, later in life, on the edge of homelessness due to relationship breakdown, medical issues and minimal savings for retirement” (Shelter WA, 2015, p. 7).

Thus, while some differences exist in the rate of homelessness for older women across Australia, the trends and number of women in WA make it a meaningful location to explore their health needs and ability to access healthcare support. Limiting the catchment area of the current study to the Perth metropolitan area further reduced the logistic and cost constraints that a national or state-wide study would require. That said, as 92% of the state's population live within the Perth metropolitan area and represents 8.6% of the national total population, findings from this study should have relevance in both WA and across Australia.

2.10 Summary

Despite many initiatives designed to reduce the level of homelessness, the rate and number of older women who are finding themselves homeless in both WA and across Australia is steadily growing.

Prior research has demonstrated that there are many complex and inter-related factors contributing to becoming homeless (structural and individual). Similarly, other studies have explored the relationship between health and homelessness and the use of healthcare services. Many of these however have involved homeless populations in America and the United Kingdom which have very different public healthcare systems to that seen in Australia. Likewise, many of these studies have targeted homeless youths or returned service men. Older women have lived diverse lives and there is evidence that older women's pathways to homelessness differ from that of other homeless populations and are influenced by a different range and combinations of circumstances including the social determinants of health and systems, particularly their social and economic disadvantage. Little is currently known about the health needs of this increasing cohort of older homeless women, including their ability to access healthcare support.

Hence, this study seeks to explore this poorly understood section of the homeless community and to provide an evidence-base that will inform the development of relevant policies and improve healthcare delivery.

Chapter 3
Methodology

This chapter outlines the overall approach used by the study. Its design draws on the emerging data of increased vulnerability of older women to homelessness in Australia, and a growing body of international and Australian literature about the healthcare needs of the wider homeless population.

3.1 Study framework

As outlined in Section 2.8 of the Literature Review, the development of the survey and interview questions draw on issues identified during the literature review but also from the work of two studies involving homeless populations by Gelberg et al., (2000) and Kertesz et al., (2014) The work by Gelberg et al. incorporated the principles of a broad social determinants approach for vulnerable homeless populations that consisted of:

- A predisposing traditional domain (which includes demographics, health beliefs and social structure) which was extended to account for vulnerable populations (including an extended range of items related to social structure, residential history, living conditions, psychological resources, sexual orientation and childhood characteristics);
- enabling factors (consisting of personal, family resources and community resources);
- need (perceived health and actual health conditions);
- health behaviour (personal health practices, utilization of health services); and
- traditional/vulnerable domains (health status and satisfaction with care).

Through his work, Kertesz developed a 33-item instrument (PCQ-H) to assess the quality of primary healthcare experienced by homeless patients in areas of patient - clinician relationship (Kertesz et al., 2014) including issues such as:

- cooperation among clinicians
- cooperation between services
- access
- satisfaction with services
- coordination
- homeless- specific needs

As the focus of the current study was older homeless women, female specific health issues and other factors impacting on them were also considered for inclusion in the data collection process. For example, because domestic and family violence affects a significant proportion of Australian women and can have significant impact on their physical and mental health, questions about the women's experience of domestic and family violence were included.

3.2 Overview of the research phases

The study utilised a sequential mixed method approach of quantitative and qualitative data collection and analysis. A sequential mixed methods model requires the findings of each phase to inform the subsequent phase of a study (Creswell & Plano Clark, 2011). Mixed methodology is a pragmatic approach to a research problem whereby the research problem is too complex to be addressed by using one method of data collection and analysis alone (Plano Clark & Ivankova, 2015). Thus, given the complex and overlapping factors around the health needs of older homeless women it was deemed most suitable for this study. While the primary focus of the study was on the women experiencing homelessness, it also drew on the broader insights of staff within the specialist homeless and the healthcare sectors to synthesise and extend the researcher's understanding of the issues discussed.

Qualitative descriptive (QD) was the methodology used for the semi structured interviews. QD is a particularly useful and relevant methodology within healthcare research. This is because it focuses on the direct descriptive

experiences of the participants (Neergaard, Olesen Anderson & Sonnegaard, 2009) rather than interpreting their experiences through the researcher's lens. Thus, QD studies are not dependent upon pre-existing philosophical or theoretical stances as with other methodologies such as Grounded Theory or Phenomenology (Sandelowski, 2000). Neeragard also differentiates QD from other qualitative methods as it is not a holistic and complex description of an ethnographic study, development of a theory such as Grounded Theory nor is it the interpretive meaning of an experience (phenomenology). Instead, it is classified as a 'rich, description of an experience or an event' (p.2). QD analysis enables researchers to stay closer to the data, describing participants' experiences in language similar to their own. QD research is the preferred method when descriptions of phenomena are desired (Sandelowski, 2000). Sandelowski (2000, p.336) asserts that "…language is a vehicle of communication, not itself an interpretive structure that must be read…". Through language, the researcher portrays the stories of their participants using their own language as much as possible. The process of presenting the data in a useful and coherent manner is a significant part of QD research (Sandelowski, 2000).

The semi-structured interviews were analysed thematically. The closed questions survey data were analysed using SPSS version 25.0. Subsequently both sets of interview findings were then examined and cross validated to build a coherent understanding of the problem and produce strategies thereby informing potential actions (Creswell, 2003). The ultimate intention was to develop strategies to improve healthcare delivery and access for this sector of the population.

Finally, these actions/strategies were then presented in Stage 3 to a panel of experts via a Delphi process as 'recommendations' to confirm the findings of the study and help prioritise the recommendations.

The following figure describes the approach used in this study.

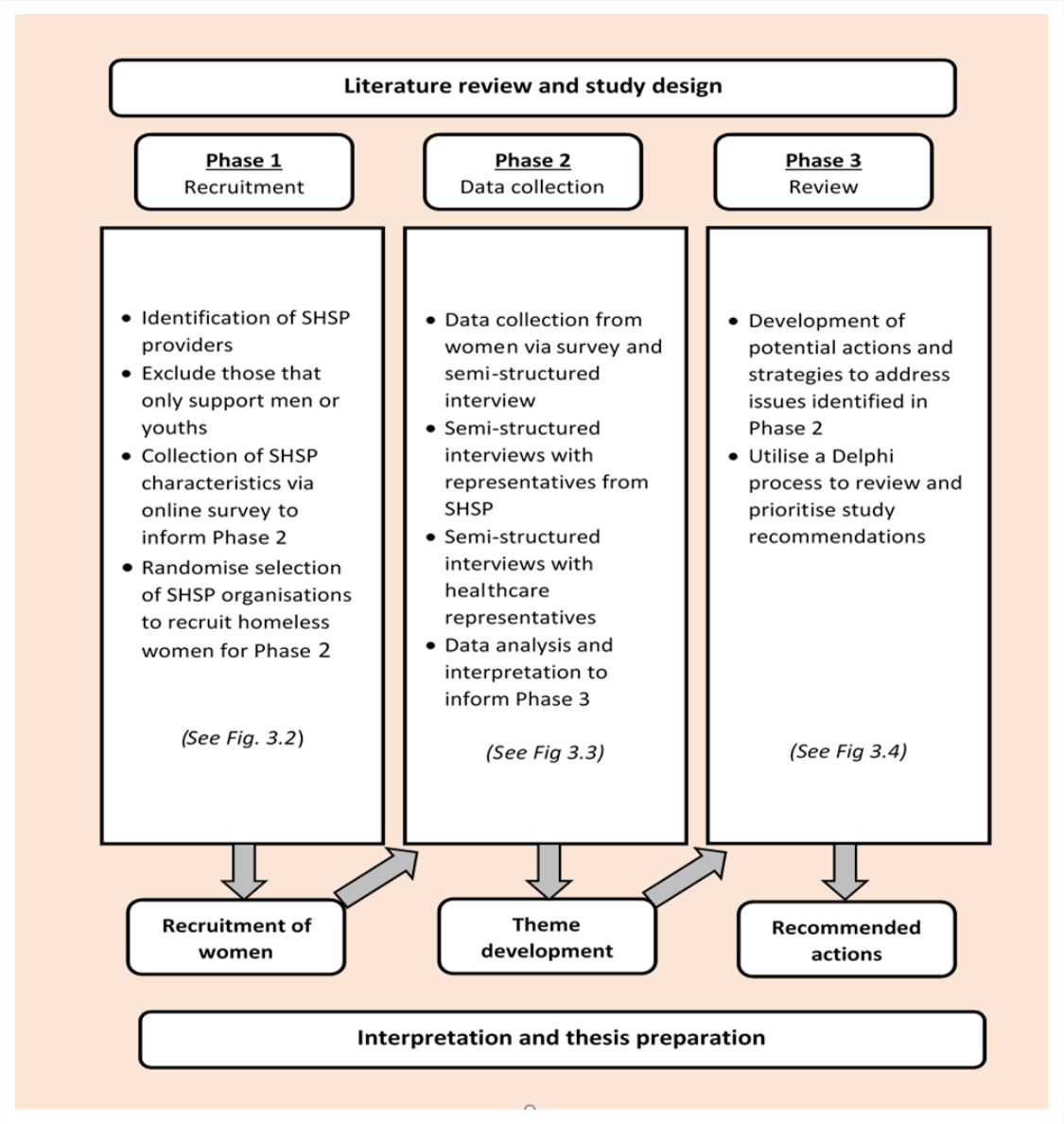

Figure 3.1 Overview of study stages

Phase 1: The principal purpose of this phase was to identify all the relevant specialist homelessness service providers (SHSP) that could be accessed by women and to invite them to provide background information about the range of services they provided and to act as a referral source for older homeless women to participate in the study.

Phase 2: The primary function of this phase of the study was to utilise the collected information from older homeless women about their health needs and concerns about accessing healthcare services. Similarly, the perceptions of representatives from the SHSP and healthcare sectors were also obtained.

Phase 3: Details of the key health needs and issues pertaining to healthcare service provision identified by analysis of the Phase 2 data were used in Phase 3 in a Delphi process that involved key stakeholders to identify key improvement strategies and priorities to inform the recommendations of this thesis. The final step of the study synthesised the findings from the Delphi Panel to justify the need for suggested improvements to the provision of healthcare services for these women in the future.

3.3 Phase 1

The primary purpose of Phase 1 was fourfold:

1. Identify all SHSPs operating in the Perth metropolitan area that provided services to older homeless women,
2. Obtain details of the healthcare needs they observed in these women,
3. Identify how they supported the women to access to healthcare services, and
4. Identify organisations through which to invite older homeless women to participate in the study.

As shown in Figure 3.2, this phase of the study comprised the following steps:

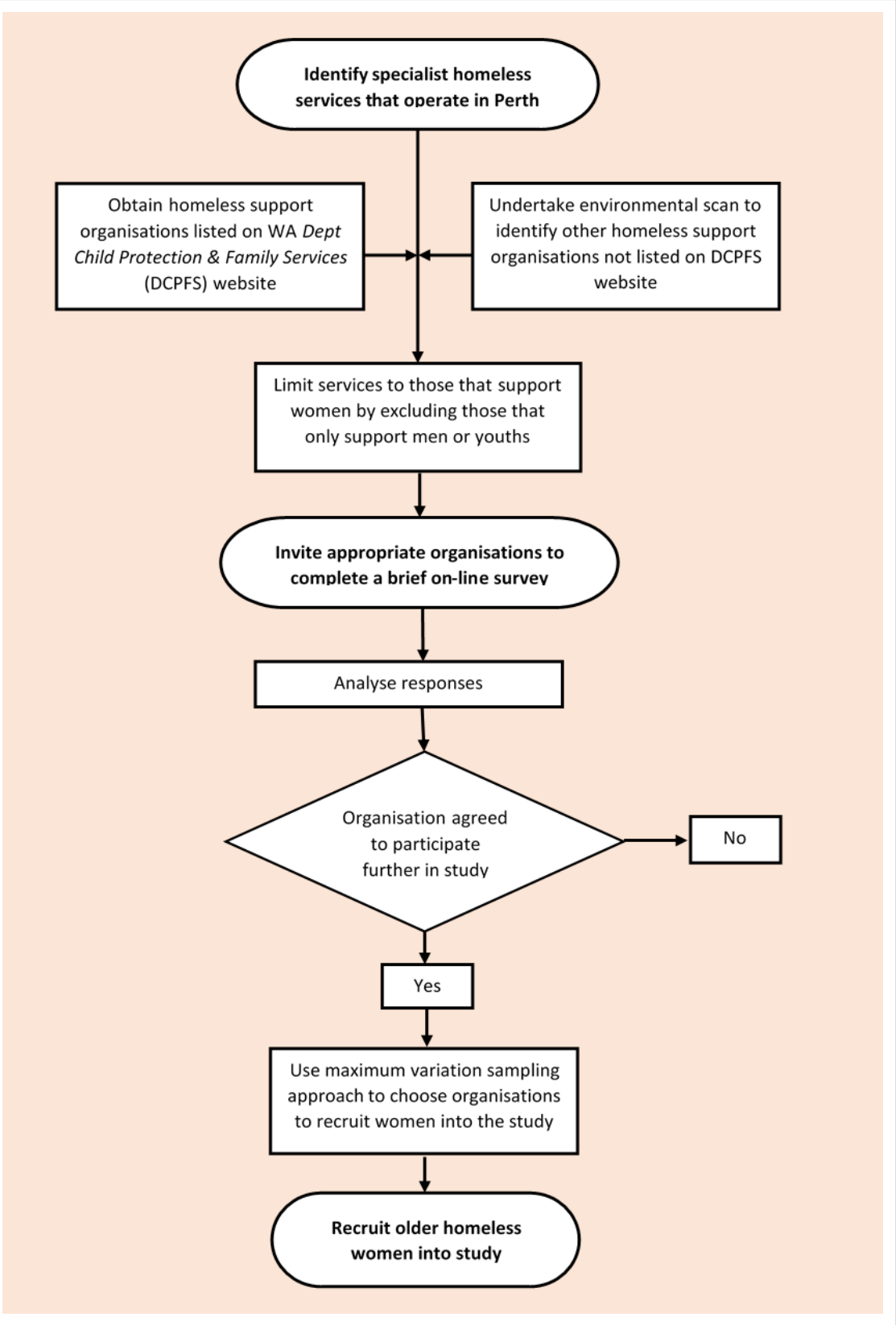

Figure 3.2 Overview of Phase 1 steps

3.3.1 Identification of specialist homelessness service providers

In Australia in 2016, the vast majority of specialist homelessness service providers received some or all of their funding from the Commonwealth Government as part of the 2015 – 2017 National Partnership Agreement on Homelessness (NPAH)[1]. Details of these organisations and the services they provided were collected and maintained by the AIHW through a secure online capturing system that captured organisational and client level details to the Specialist Homeless Online Reporting (SHOR) website into the Specialist Homeless Information Database (SHED). In WA, this data base was maintained and validated by the Department of Child Protection and Family and Support (DCPFS)[2].

A list of 40 Commonwealth funded organisations that provided specialist homelessness services in the Perth metropolitan area was obtained from DCPFS via their web site (public access). Following review of each organisation's mission statement on their organisation's web site or following a telephone call to the organisation, those that solely provided homeless services to only males or young people were excluded (n = 8 leaving 32 organisations from the original 40).

Further consultation with the homeless sector identified three additional non-government services not on the DCPFS list that may have provided services to older women which were subsequently invited to participate in the study.

3.3.2 Invitation to specialist homelessness service providers to participate in the study

All of the 35 specialist homelessness service provider organisations identified through the processed described above were invited to participate in a survey to confirm to they provided services to women and collect details about their on-site healthcare services and referral pathways.

For the vast majority that were on the WA SHED list (DCPFS funded services on the Department's public access web site), the Director Contract Branch,

[1] On July 1 2018, the *National Housing and Homelessness Agreement (NHHA)* replaced the former *National Affordable Housing Agreement (NAHA)* and the former *National Partnership on Homelessness (NPAH)*.

[2] On 1 July 2017, the DCPFS was restructured into the Department of Communities as part of the as part of the Machinery of Government Changes.

DCPFS (see Appendix C) sent a letter on 26 August 2016 to the organisations' CEOs encouraging them to participate in the study and advising them that they would subsequently hear directly from the researcher.

Two weeks later, the CEOs of all the organisations identified as potentially as ones that supported homeless women were sent an email by the researcher on 8 September 2016 (see Appendix D) outlining the study and inviting them to complete a short (10 questions) online survey to confirm that their organisation provided services to older women, details of the types of services they provided, how they supported the health needs of their clients and whether they were willing to participate further in the study (see Appendix E). This process was used to facilitate engagement with the homeless service providers in order to recruit homeless women into the study and to inform the development of the study's surveys and questionnaires.

Follow-up emails and phone calls to non-responding organisations were made two and three weeks after the initial approach email, with the survey being closed after four weeks (7 October 2016).

Data from this survey enabled confirmation of those SHSPs that provide services to older women, confirmed their willingness to participate in follow-up interviews, identify older homeless women who would be potentially willing to participate in the study and to inform the development of the interview questions for both the women and the SHSP staff involved in the study.

3.3.3 Recruitment of older homeless women

With the aim of recruiting approximately 20-30 women into the study and to minimise the potential of selection bias, a cross-section of SHSP organisations invited to participate in the study was identified using a purposive sampling strategy (Damianakis & Woodford, 2012). Purposive sampling is a non-probability sampling technique which selects the sample based on what is known about the target population in concordance with the aim of the research and recruits those who possess the maximum amount of information and knowledge about the topic. Maximum variation sampling takes into account the smaller qualitative sample size and aims to recruit a broad variation of participant demographics who

nonetheless have in depth knowledge or familiarity around the specific experience or phenomenon. This process was limited to those organisations that completed the online survey and indicated they willingness to participate further in the study. As indicated on Table 3.1, the process involved categorising the organisations based on the reach of their services to include state-wide, metropolitan, inner city and suburban; the type of services they provided including comprehensive, limited support and accommodation and whether they specifically targeted women or not, provided on-site healthcare and whether they provided referral to other healthcare providers. Drawing on this information, the maximum variation sampling process involved choosing approximately 50% of SHSP services operating within the Perth metropolitan area that provided a similar distribution across the categories described above as the whole sample. Detail of the characteristics of the maximum variation sample are shown in Table 3.1 with the selected organisations ultimately being the source of both homeless women and staff to be involved in Phase 2 of the study.

Having identified those organisations who stated their willingness to support the study, the researcher subsequently met with senior representatives of the homeless support organisations 'selected' by the maximum variation sampling process to more fully describe the purpose of the study and to develop trust between the organisation's senior staff and the researcher. Following these discussions, the organisations agreed that they would identify and approach potentially suitable older homeless women (aged 50 and over) to participate in the study. The women were provided both flyers outlining the purpose of the study and the requirements expected from them and the number of the researcher whom they directly contacted should they wish to proceed (see Appendix F, Appendix G)

Interested women were advised of the confidential nature of the study and that their relationship with any service provider would not be impacted by their choice to participate or not in the interview. None of the women decided not to participate and completed a consent form before participating further in the study.

Table 3.1 Comparison of service characteristics for client interviews – Maximum variation sampling

Pooled information	Client base	Service category	Female specific	Onsite healthcare	Refer to health services
Services willing to continue	State-wide = 6 *Limited C&M = 2 Metro wide = 1 Inner city = 2 Suburban = 2 *Total = 16*	Comprehensive = 8 Accommodation = 3 Support = 5 *Total = 16*	Yes = 4 No = 12 *Total = 16*	Yes = 6 No = 10 *Total = 16*	Yes = 15 No = 1 *Total = 16*
Maximum variation sampling	State-wide = 3 Limited C&M = 0 Metro-wide = 1 Inner city = 1 Suburban = 2 *Total = 7*	Comprehensive = 3 Accommodation = 2 Support = 2 *Total = 7*	Yes = 2 No = 5 *Total = 7*	Yes = 3 No = 4 Total = 7	Yes = 7 No = 0 Total = 7

*services specifically limited to country or metropolitan area
Client-base: the predominant geographical population cohort – e.g. state-wide, metropolitan-wide, specific suburban location.
Comprehensive services: provide onsite accommodation, counselling, support services, advocacy, and referrals.
Accommodation: where the service is predominately focussed on providing housing and a place to stay, including crisis accommodation.
Support services: agency provides a range of services including meals, shower facilities, clothing, personal development,
Onsite health care: Onsite clinic service or visiting health services including the Mobile GP Service, Homeless Healthcare, mental health services.

3.4 Phase 2

The second phase of the data collection and analysis stage of the study utilised both quantitative and qualitative approaches to obtain details of the health needs and issues concerning healthcare access from a number of older homeless women, and representatives from both the SHSP and healthcare sectors.

The primary focus of this part of the study was to obtain personal details from the homeless women and as noted earlier in this chapter to cross validate their experiences with representatives from the SHSP and healthcare sectors. All of the women's interviews took place within the facilities of special homelessness service through which the women were recruited, except for one woman who elected to be interviewed in her short-term accommodation. SHSP and healthcare providers were interviewed in their work locations.

The face-to-face consultation with the women was intentionally designed as a two-part process that consisted initially of a general survey to gain baseline information about their health and homelessness before embarking on a more personal and deeper exploration of their lives through a semi-structured interview. This step was to help the women become more comfortable and develop a level of trust between the participant and the researcher (Dempsey, Dowling, Larkin & Murphy, 2016). Asking simpler closed, relatively straightforward and easily answerable questions in the survey also helped focus the women's responses on the health aspects of their homelessness before probing with more sensitive and personal interview questions about their health whilst homeless.

Representatives from the SHPS and healthcare sector were interviewed using a similar instrument to that used with the women but modified to allow for the different perspective and experiences (see Appendix Q, Appendix S).

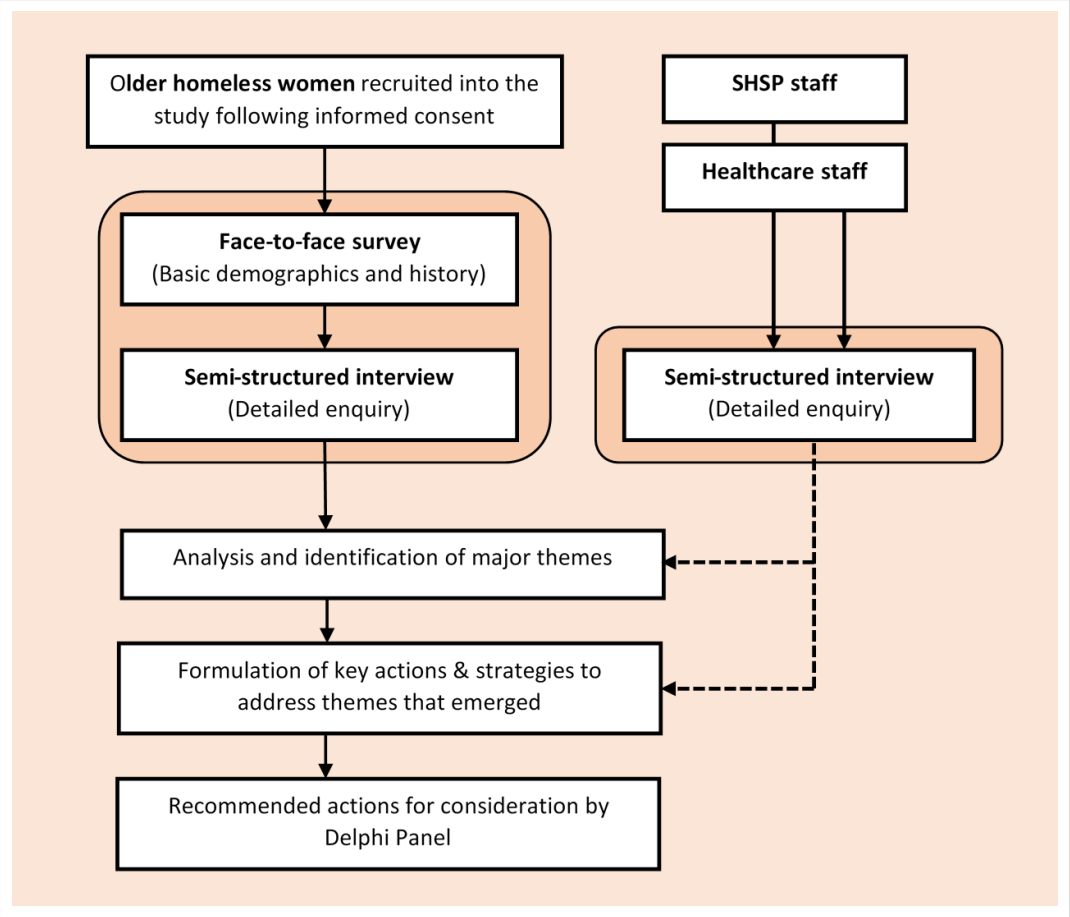

Figure 3.3 Overview of Phase 2 steps

3.4.1 Development of the women's survey

The survey explored included basic demographic and contextual information such as age, level of education, family and social support, residential history, duration of homelessness and living conditions. It also included questions about their (self-rated) health conditions and types of health services utilised. Other questions explored the women's roles as family carers, their safety concerns, and their experience of domestic and family violence and other trauma. (see Appendix I*)*. The choice of questions was based on the literature and on discussion with homeless service and healthcare providers. The questions on domestic violence were developed in consultation with a clinical psychologist specialising in domestic violence.

3.4.2 Development of the women's semi-structured interview

The semi-structured interview also drew on the work by Kertesz and Gelberg's Behavioural model for Vulnerable Populations to build this study upon.

These studies informed the nature of the questionnaire items to ensure it achieved a balance of information about predisposing factors, historical and current health needs and the barriers and enablers to accessing healthcare. (See 0*).*

The researcher read the women's responses to both the survey and questionnaire to confirm and reiterate that their response had been captured correctly. Whilst the interviews were transcribed, the researcher also took comprehensive notes and documented responses to each question and the prompts on the interview schedule due to the inability of accessing a transient population for member checking to ensure all of the data was correctly captured. This process was assisted by interviewing the SHSP and the HCP as well. This mitigated any bias in the responses received and enabled the researcher to explore any aspect of a response that had not been fully foreseen prior to the interview.

3.4.3 Piloting of research tools for women

Prior to commencing the study, the survey and interview tools were piloted with an older homeless woman visiting one of the SHSP facilities.

While it was initially planned that the woman would self-complete the survey by herself prior to commencing the face-to-face semi-structured interview, this woman requested the researcher to read the questions to her and fill in the answers for her due to her difficulty with reading. This change in process seemed to help develop a personal connection and trust between the participant and the researcher and thus all women in the study were offered the option of self-completion of the survey or having it read to them. Where the researcher was asked to read the questions, each response was verified before progressing.

The survey and semi-structured interview took approximately 45 minutes to complete with the pilot-participant stating that the process felt comfortable and had been a personally positive experience as she was keen to share her story and talk about the range of issues relating to her homelessness and health.

3.4.4 Development of the specialist homelessness service providers and healthcare providers interviews

While the homeless older women were the primary source of information for this study, it was recognised that the ability to cross-validate and potentially extend the level of understanding to factors that impact on the women's feedback would be significantly enhanced by undertaking similar interviews with providers from both the SHSP and healthcare sectors who were working with older homeless women. In addition to the women participating in the study, these providers could draw on their wide range of experience, adding their insights and perspective on key aspects of health and homelessness needs and service provision including accessibility and acceptability; the client-clinician relationship; coordination of services and continuity of care.

The questions from the women's semi-structured interview format were used as the basis to develop questions for both the specialist homelessness services providers and the healthcare providers. For example, whilst the women's questions focussed on their own personal stories of their homelessness and health needs, the providers were asked to describe their insights into the health needs of older women who had utilised their homeless or healthcare service, including how they considered homelessness may have impacted on the women's health. Providers were also asked to reflect on their experience as homelessness or healthcare providers to describe the barriers and enablers for these women to access healthcare and if they considered current services were addressing the health needs of this population. Similarly, the women and providers were also asked to share their experience of cooperation and coordination between services and for their suggestions for ways of improving healthcare and service delivery. (See Appendix Q, Appendix S).

3.4.5 Piloting of research tools for specialist homelessness service providers and healthcare providers

The semi-structured interview schedule for Specialist Homeless Service Providers and healthcare providers was piloted with a SHSP Manager and a nurse practitioner from a general practice that specialised in homeless healthcare. Minor grammatical changes were made to some questions to

improve their meaning including a question relating to barriers and enablers to older women's access to healthcare services was divided into two parts to help simplify the responses. An additional question was added to enable providers to offer their explanation for the reasons for these barriers and enablers but otherwise the format and sequencing of questions and associated prompts appeared to work well, and no further changes were required.

3.4.6 Women's interview settings

The participants were all interviewed individually in a private setting. Most were interviewed in a counselling room, private meeting room or a room set aside for visiting practitioners at the SHSP site, but a few elected to be interviewed in their personal rooms in a temporary accommodation site or private rental flat.

3.4.7 Women's interviews

Following an initial introduction by a senior staff member of the SHSP, the interviewer (researcher) further explained the study and clarified any concerns the woman may have with the interview process. None of the women indicated an unwillingness to participate and those women who participated expressing they were keen to share their experience. Twenty two women aged 49-82 recruited from six of the seven selected sites completed the interview process. All were interviewed in English except for one woman from a Culturally and Linguistically Diverse (CALD) background who was interviewed via telephone interpreter service.

3.4.8 Specialist homelessness service provider interviews

Semi-structured interviews were conducted with eight SHSP staff who mainly came from the six organisations that facilitated the identification of homeless women for this study but also included a staff member person from an organisation that provided services from women escaping domestic and family violence.

Face-to-face consultations were conducted in private consulting areas involved five service managers and three support/case workers with extensive experience in working with homeless women.

3.4.9 Healthcare providers interviews

Eight healthcare providers (from five agencies) with experience of working with homeless people consisted of three medical practitioners, three nurses, one psychologist and one healthcare adviser were interviewed. These individuals worked in different parts of the healthcare system ranging from community based services, primary health and acute care services (including emergency department). The interviews explored key aspects of healthcare services and explored their suggestions to improve healthcare service delivery to better meet the health needs of this client group.

Face to face interviews were conducted in a range of settings including general practice clinics, offices and consulting rooms. All the interviewees have extensive health related experience working with people experiencing homelessness including older women.

3.4.10 Data analysis for Phases 1 and 2

3.4.10.1 Quantitative data

Survey data in this thesis are reported as simple frequencies calculated using SPSS v24 (IBM Analytics, New York, USA). Due to the relatively low number of respondents, comparative statistics have not been provided.

3.4.10.2 Qualitative data – thematic analysis

Upon completion of the semi-structured interviews by the women, SHSP and healthcare works, the audio files were fully transcribed into text by an independent person. As it was not possible have the women verify the recordings due to their being a transient population, on receipt of the transcribed files, the accuracy each was verified against the recordings by the researcher, with a sub-set also reviewed by a supervisor. This was also mitigated by interviewing the SHSP and the HCP as well as the women as part of the cross validation and exploration process as noted earlier (Section 2.1).

Interview data were managed using the qualitative data management software, QSR NVivo 11 (QSR International) with the researcher following by

Braun and Clarke's Thematic Analysis Processes (see Table 3.2) which incorporated highlighting significant statements, creating initial codes which were subsequently organised into a visual hierarchy of parent and child nodes within the software.

Table 3.2 Braun and Clarke's Phases of Thematic Analysis

Phase	Description of the process
1.Familarising yourself with the data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2.Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data to each code.
3.Searching for key themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4.Reviewing themes	Checking in the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis
5.Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
Producing the final results	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

(Braun & Clarke, 2006).

Using NVivo, the transcribed text was organised into a visual hierarchy of parent and child nodes. Search and query functions were utilised to identify words and short phrases that captured and highlighted participant responses.

Using an iterative process of refining assignment of quotes to the codes and the grouping of these into sub-themes ultimately lead to the identification of the major themes that captured the key essence of the interview conversations. Once all the data had been comprehensively coded into sub-categories, the researcher refined the codes into sub-themes and possible themes using a process that has been fully described in Section 6.2.1. Notes were made regarding the data trends and emerging themes by the researcher and then explored and validate with her supervisors.

Although the questions asked of the SHSP (see Appendix Q) and healthcare staff (see Appendix S) were very similar to those asked of the women (see

Appendix J), theme development was based solely on the responses provided by the women. That said however, responses from the other interviews were used to support and provide greater insights to the detail emerging from the analysis of the women's responses.

3.4.10.3 Qualitative data: rigour

The rigour in the data was evaluated according to credibility, dependability, confirmability, transferability and authenticity (Colorafi & Evans, 2016; Cope, 2014).

Trustworthiness criteria

Credibility - Credibility refers to the evidence of 'truth' in representation and interpretation of participant views. This study will achieve credibility through reporting on participant engagement; reporting on the interview process and maintaining a detailed research process.

Dependability - Dependability entails providing a consistency of the data over similar conditions including collaborative decision making regarding common themes by supervisors thereby managing individual researcher bias.

Confirmability - Confirmability includes the ability to demonstrate that the data represents participant viewpoints and not pre-existing researcher bias(es). The candidate will achieve this through describing the process for coding of data and demonstrating themes within the data with pertinent quotes. Further to this, examples in thesis of decisions regarding coding structure are located on page 72 onwards.

Transferability - Transferability relates to the degree to which findings can be generalised and applied to other similar contexts. Specifically, sufficient information will be given in regard to both the participants and the research context to allow readers to evaluate transferability.

Authenticity - Finally, authenticity refers to the extent of faithful expression of participants' feelings and emotions. This has been achieved by the use of pertinent quotes selected for interviews to highlight themes across all 3 participant groups.

3.5 Phase 3

The final phase of this study sought broad stakeholder input through a Delphi process. The aim of this phase of the study was to use a panel to consider study's major findings and prioritise the recommended actions based on their own extensive experience with homelessness. An overview of the steps from Phase 3 and how they informed steps in this phase of the study are outlined below and shown in Figure 3.4.

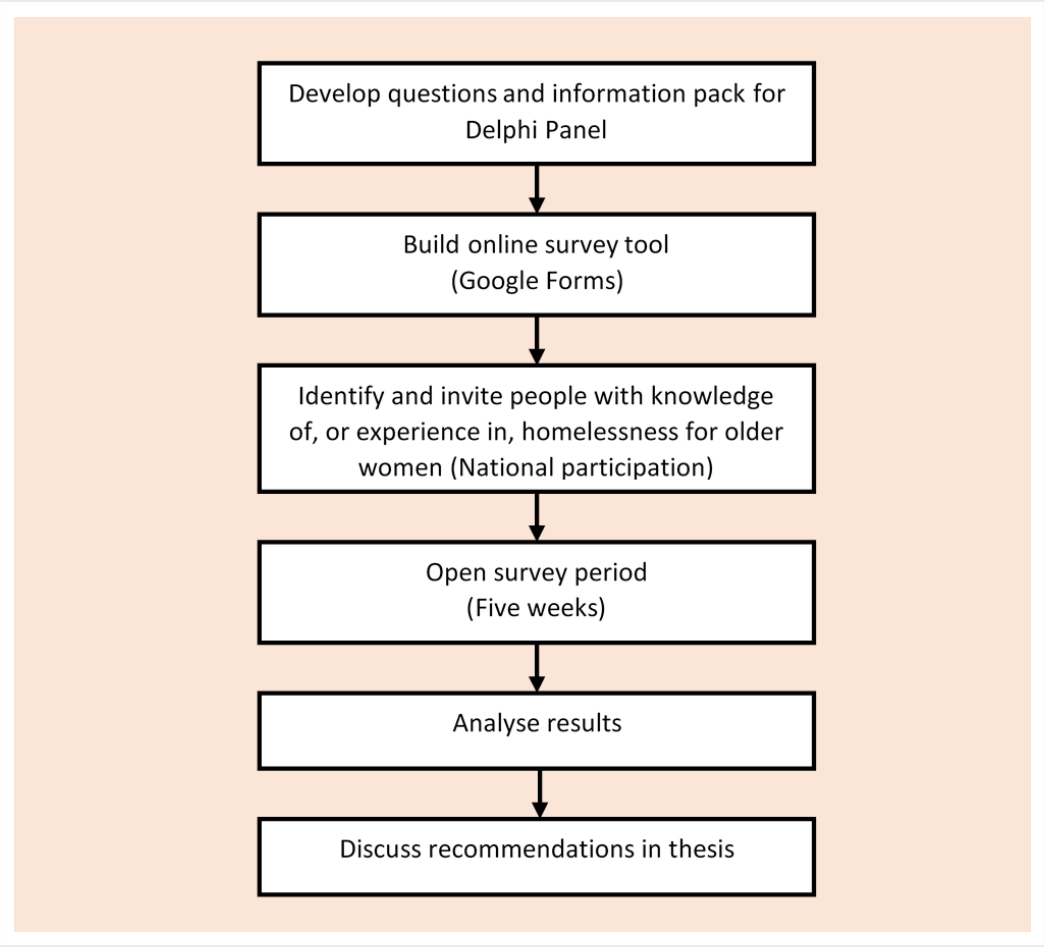

Figure 3.4 Overview of Phase 3 steps

As the development of the information used by the Delphi process was totally informed by the major themes that emerged from analysis of the women's interview responses and the information provided by the SHSP and healthcare staff, most of the details pertaining to this are found in Chapter 8. Some of the more generic information is provided in the following sections.

3.5.1 Delphi process

Web-based survey tools to undertake a Delphi study have been found to result in high response rates and increased level of data quality in a time efficient and user-friendly manner (Gill, Leslie, Grech & Latour, 2013). This study utilised a similar approach.

In a modified single round Delphi process, participants were provided with an online link to access a short summary of information identified through this study (see Appendix U) as pre-reading prior to responding to the survey. The survey page listed the nine recommended actions and asked the Panel members to respond to five questions using both open-ended questions and closed statements (de Villiers, M. R., de Villiers, P. J. T., & Kent, 2005).

The background information was stored in a secured folder on Google Drive and the web-based survey developed in Google Forms (Appendix V).

Prior to use, the survey was tested by two researchers and a person from the homelessness service sector to seek feedback on clarity of the questions, flow and time to complete the survey. Following this review, some minor changes were made to the lay out of the document for ease of completion by the participants.

3.5.2 Participant selection and invitation

The Expert Panel in the Delphi process were drawn from SHSP, the healthcare sector and women with prior experience of homelessness and local and national researchers/ advocates specialising in older women's homelessness and homeless healthcare. Each potential participant was sent an email (see Appendix T) that outlined the purpose of the study with links to a document that outlined the study's major findings, a list of the potential actions and strategies (recommendations) (see Appendix U) designed to address the findings and a series of five questions to help in the validation and prioritisation process (see Appendix V). The Delphi process was piloted on a SHSP staff member and modified slightly to improve ease of completion before been distributed to the Panel which consisted of both local and interstate participants. Full descriptions of the Delphi process are provided in Chapter 8.

Potential participants were advised that all information would be kept confidential and only aggregated information would be released from the study. It was made explicit that the researcher was seeking feedback based on both the provided information and based on the participant's own knowledge and expertise.

The survey was open from the date of email (18 April 2019) for just over five weeks (26 May 2019). Reminder emails were sent to all individuals on 7 and 24 May 2019.

3.5.3 Data analysis for Phase 3

Data collected during Phase 3 of the study was simply tabulated and simple percentages calculated using Microsoft Excel (2016).

3.6 Ethical considerations

This project conformed with the NHMRC's National Statement on Ethical Conduct in Human Research 41 (NHMRC 2007, updated May 2015) and was approved by the University's HREC (26 July 2016 / 016100F). HREC subsequently approved changes to the women's survey to include questions relating to domestic and family violence on 13 December 2016).

All participants involved in this study received detailed information that explained the purpose of the study and that participation was purely voluntary. Each participant was assured all details captured by the study would be treated in confidence and only job descriptors and aggregated information would be used in the reporting process. Consent forms were signed in advance to participation in the study by the homeless women or inferred by the completion of any on-line survey. Information from healthcare and specialised homeless service providers did not require details at an individual person level and thus they did not need to complete a consent form.

3.7 Confidentiality

Confidentiality of data was strictly adhered to. Data collection spreadsheets and electronic data were kept in a secure, limited access computer folder in the Institute for Health Research at UNDA. Transcripts from interviews had any

identifying details removed at the time of preparation. All electronic files, interview transcripts, focus group transcripts and survey data are accessible only to the research team and protected by password access. Paper copies of the interview process were stored in a locked filing cabinet within a locked room of the Institute.

All results, presentations and any publications only utilise aggregated information except for profile descriptions where the names and other identifying information have been omitted or changed to preserve their anonymity.

The next chapter will describe the results from the online survey of Specialist Homelessness Service Providers.

Chapter 4

Specialist Homelessness Service Provider Survey Results

This chapter outlines the findings of the online survey of Specialist Homelessness Service Providers (see Appendix E). The primary purpose of the survey was to confirm which organisations provided services to older women and their willingness to participate further in the study. Other supplementary details about the range of services they provided, including healthcare, were explored to provide an overview of type of services providers that operated within the Perth metropolitan area. This survey was designed to enable the researcher to engage with the homeless service providers in order to facilitate access to women who could be invited to participate in the research.

Of the 35 organisations approached (see Section 3.3.1), 25 (71%) SHSPs completed the survey. Two large organisations however, forwarded the survey to branches within their organisations resulting in a total of 29 survey responses. All responses were included in the analysis as the branches provided quite different services to each other.

The survey questions have been grouped into broad categories as shown below with the exception of those pertaining to the organisation's name, location and contact details. These have been withheld for confidentiality purposes.

4.1 Support for older women

Q3	Does your organisation provide services (other than health specific services) for women aged 50 years? (Yes/ No / Example)

Of the 29 service providers who responded to the survey, 22 (76%) affirmed that they provided support services (other than healthcare) for women with the remaining seven providers (24%) confirming they did not provide support services for older women. Although overall only 22 provided services for women, all 29 respondents completed the survey and their feedback was included in the analysis and reporting.

The service providers who responded (multiple response) to the affirmative were asked to name the services they provided. Services that were mostly provided are for emotional support (36%) and crisis accommodation (36%) Services least likely to be provided were transitional housing (9%) and day centre services (9%) (see Table 4.1).

Table 4.1 Types of support services offered by SHSP (Multiple response)

Response *(n=22)*	*n*	% respondents
Emotional support	8	36.4
Crisis accommodation for women *	8	36.4
Tenancy, longer term housing, retaining own home support	7	31.8
Emergency relief **	6	27.3
Support to access longer term housing	6	27.3
Support women at risk eviction & women seeking to stay in own homes after DV	6	27.3
Counselling ***	5	22.7
Individual case management	4	18.2
Support and referral for drug and alcohol services	3	13.6
Advocacy, linkage and referral	3	13.6
Provision of transitional housing	2	9.1
Day centre ****	2	9.1

* included. children escaping domestic violence), ** included food, debt reduction, Bills transport, material assistance, chemist assistance, assistance to regain driver's licence; legal support/(documentation; *** included psychological counselling, counselling to regain self-esteem and self-confidence, referrals to range of counselling services; **** included recreation, showers, clothing, meals, exercise group, choir, holistic services, financial counselling, street law, personal development.

4.2 Healthcare services provided to older women

Q4 Does your service deliver healthcare to older women?

The majority SHSP organisation did not provide healthcare services to older women (79%).

Q5 Please describe the types of healthcare services your organisation provides for older women

Of the six SHSP that reported providing healthcare services on site to the women, the most common services provided were nursing (50%), counselling (50%) and nurse counselling (50%). Other services provided on site included two GP services, a clinical psychologist, and a drug and alcohol counselling service. Only one SHSP provided Aboriginal support services and one provided domestic

violence advocacy and counselling. Only one SHSP provided allied health, dentistry, massage, yoga/mindfulness (see Table 4.2).

Table 4.2 Specific services provided to older women (multiple response)

Response *(n=6)*	*n*	% respondents
Nursing onsite	3	50.0
Nurse counselling	3	50.0
General counselling on site	3	50.0
GP on site	2	33.3
Clinical psychologist	2	33.3
Drug and alcohol counselling	2	33.3
Aboriginal support services	1	16.6
Domestic violence advocacy and counselling	1	16.6
Other*	2	33.3

* Included two organisations providing a range of services including: allied health onsite; dentistry in dedicated unit; massage reflexology; exercise yoga and mindfulness; DV advocacy and counselling; HACC; Dietician; Flu vaccination

Q6 How many older women (50+ years) does your organisation deliver health services to in an average calendar month?]

Of the six organisation that stated they provided healthcare services to the older female clients, only five provided information about the average number of women utilising this service. One stated they provided care to more than 20 women per month whilst two others stated their demand was less the 20 women per month and two were unsure of the number of women for whom they provided health services.

Q7 What percentage of your client base are older women?

Of the 14 organisations that responded to this question, one noted 59% of their client base comprised older women, one organisation had a client base of 40% older women, three organisations 20- 25% and 10 organisations identified their client base of older women was less than 10%.

Q8(a) Does your organisation refer women to other health services

Of the 29 survey respondents, the majority (72%) noted that they referred women to other health services, three did not refer and five indicated that they were unsure as to whether their organisation referred or not (see Table 4.3).

Table 4.3 Number of services referring women to other health services

Response *(n=29)*	*n*	% services
Yes	21	72.0
No	3	10.0
Unsure	5	17.0
Total	**29**	**100.0**

Q8(b) Please list the name of any other health service providers your organisation refers older women to

The healthcare services most commonly referred to included general practitioners (55%), mental health services (77%) and alcohol and other drug services (46%). A wider range of other services to that women were referred to included counselling, women's health and community health services, allied health, dental, Aboriginal health, sexual abuse counselling, Health and Community Aged Care (see Table 4.4).

Table 4.4 Type of health service referred from SHSP (multiple response)

Response *(n=22)*	*N*	% of service referrals
General practice / includes visiting GP e.g. Street Doctor	12	54.5
Mental Health and counselling	17	77.3
Alcohol and other drugs (AOD)	10	45.5
Women's specific services *	6	27.3
Community health	5	22.7
Hospitals and Emergency Dept.	5	22.7
Chronic disease / diabetes management	3	13.6
Allied Health/ Dentist	5	22.7
Aboriginal health services	2	9.1
Other**	3	13.6

* Included women's health service, sexual assault referral, domestic violence service specific, sexual abuse counselling; ** Included Health and Community Aged Care; Continence Nurse; Legal Aid.

Q9 Why did your organisation choose to refer older women to the health services listed in the previous question?

Respondents were asked to explain why they referred the clients to the services noted in the previous question (see Table 4.4). The majority of

respondents said that this was because they did not offer the services themselves (91%) or that the referred service met the client's specific health needs (69%). Other reasons cited were appropriateness of service, accessibility and cost to client, quality of service to whom clients are being referred, gender and culturally specific services and domestic violence specific services. Cost to the organisation was also listed as a factor for one organisation (see Table 4.5).

Table 4.5 Reasons for health services referrals (Multiple response)

Reponses (n=22)	*N*	% respondents
We don't offer the service	20	90.9
Meet the client's health specific needs	15	68.2
Appropriateness of service	10	45.5
Accessibility	9	40.9
Cost to client	8	36.4
Quality	7	31.8
Gender specific services	5	22.7
Reputation	4	18.2
Culturally and Linguistically diverse specific	1	4.5
Aboriginal specific	1	4.5
Domestic violence specific	1	4.5
Other *	3	13.6

* Included: To assist tenants to sustain their tenancy; sometimes the only service available of its kind to clients, cost to our organisation

4.3 Other services provided to older women

Q10 Does your organisation refer older women to any of the following services (please include referrals and visiting services)?

The majority of the SHSPs surveyed referred women to a range of services and visiting services to meet the women's needs of accommodation and food, their financial and legal needs as well as for emergency crisis relief, employment support and advocacy. Women were also referred to clothing services, life skill training and in-house day centre activities (if available). The largest percentage of services referred to were counselling (86%), Financial planning (82%) and legal (77%) and accommodation services (73%) (see Table 4.6).

Table 4.6 Referrals and visiting services referred by SHSPs (Multiple response)

Responses *(n=22)*	*n*	% of respondents
Counselling	19	86.4
Financial Support / Planning	18	81.8
Legal Services	17	77.3
Housing / Accommodation Services	16	72.7
Emergency Crisis Relief	16	72.7
Advocacy Services	15	68.2
Food Services	15	68.2
Employment Support	13	59.1
Security and safety	9	40.9
Clothing Services	8	36.4
Training in Life skills	5	22.7
Day Centre Social Activities	4	18.2
Other*	1	4.5

* Included essential items such as whitegoods, removal costs and personal items are covered by philanthropic applications and donations.

4.4 Summary of key findings

Of the 29 specialist homeless services who responded to the survey, 22 affirmed they provided support services (other than healthcare) for older women. Most of these were for emotional support and crisis accommodation. Only six services (11%) delivered some healthcare services on-site although most referred the women to other health services, including general practitioners, mental health services, alcohol and other drug (AOD) services and specific women's specific health services. Only 13% of referrals were to emergency departments. Other service referrals included counselling (86%), financial support and planning (82%), housing and emergency relief (73%), advocacy services, food services (68%).

Of the 29 who completed the survey, 16 (46%) said they would be happy to continue to participate in the study, including assisting with facilitating interviews with older women clients. Using a maximum variation sampling approach, seven of the 16 sites were selected to provide a broad representation of homeless services available in Perth and through which to recruit older homeless women into the study. The results from the survey they undertook are provided in the next chapter.

Chapter 5
Women's Survey Results

This chapter provides profiles of the women who participated in the study and the results from the survey the formed the first part of the face-to-face interview with women (see Section 3.4.1). It provides details about the women's sociodemographic characteristics, their family and support networks; current and previous residential history, their; personal safety concerns including experience of domestic and family violence and other violence whilst homeless; self-reported health status; including their current and previous health conditions and concerns and the health services they have utilised whilst experiencing homelessness.

The survey (see Appendix I) was completed by the 22 women and took between 60-90 minutes per person to complete. The survey sought to address the Research Question: What are the living arrangements, self-reported health conditions and healthcare services utilised by the women?

5.1 Profiles of the older homeless women

The homeless women who participated were recruited from seven homelessness services across the Perth metropolitan (see Section 3.3.3), encompassing a range of different settings and living arrangements and were aged between 48 to 82 years at time of interview (January and May 2017).

The table below utilizes some information acquired during the survey and the interviews to provide the reader with some details of the background of the women recruited for the study. Most of the women interviewed were residing in transitional older women's accommodation, some in short term untenured accommodation whilst others lived in a range of situations including sleeping rough on the streets, in their cars or crisis accommodation (see Table 5.1).

Table 5.1 Overview of living arrangements and backgrounds of homeless* women interviewed

**Name	Age	Current living arrangements	Duration of homelessness	***Stage of homelessness	Country birth	ATSI
Ruby	71	Transitional	> 10 years	Chronic/ Intermittent	Australia	Yes
Brenda	62	Transitional	<3 months	First time	Uganda	No
Stella	56	Short term unit	2 years	Chronic / Intermittent	Australia	No
Sarah	55	Short term rental 'Street to Home'	4 years	Chronic/ Intermittent	NZ	No
Jennifer	69	Transitional	6 years	Chronic/ Intermittent	Australia	No
Tanya	52	Transitional	10 years	Chronic/ Intermittent	England	No
Alison	56	Transitional	< 3 months	First time	Australia	No
Angela	50	In car	3 years	Chronic/ Intermittent	England	No
Amelia	71	Short term unit	4 years	Chronic/ Intermittent	Australia	No
Beth	72	Short term unit	4 years	Chronic/ Intermittent	Australia	No
Mary	60	Transitional	10 years	Chronic/ Intermittent	Australia	No
Dawn	66	Short term unit	2 years	First time	Australia	Yes
Gwenda	65	Short term unit	18 months	Chronic/ Intermittent	Australia	No
Gina	51	Night shelter (mixed gender)	14 years	Chronic/ Intermittent	Australia	Yes
Rose	52	Lives on streets	18 months	First time	Australia	Yes
Marie	48	Women's Safe House	30 years	Chronic/ Intermittent	Australia	No
Molly	54	Transitional	3 months	First time	Holland	No
Carol	60	Un-tenured State Housing	3 years	Chronic/ Intermittent	Australia	Yes
Daphne	54	Transitional	1 year	Chronic/ Intermittent	Australia	Yes
Katy	60	Transitional	2 months	First time	Bosnia	No
Denise	82	Transitional	11 months	First time	Australia	No
Pamela	52	With local church family	2 years	Chronic/ Intermittent	New Zealand (Maori)	No

* Homeless according to AIHW definition; **names of the women have been changed for confidentiality reasons ; *** Stage of homelessness: Chronic homelessness = episodes of homelessness lasting more than a year; Intermittent homelessness = episodes in and out of homelessness for periods of less than a year (Fazel et al 2014)

The profiles outlined below provide an overview of some of the women's personal histories and describe the diversity of their circumstances through to the time of their interview, including the underlying and contributing factors which led to and impacted on their experience of homelessness. Profiles of all of the participants can be found in Appendix K with just five shown below to provide insights to the diversity of their circumstances. The names of all the women have been changed to protect their confidentiality.

Denise

Denise, aged 82 came from a wealthy family. She had been living in her own home unit south of the city, with river views. Denise's sister falsified her name on her property title deed, which resulted in Denise having to move out. She moved into backpacker accommodation in the inner city where she had a dizzy spell, so she was sent to Royal Perth Hospital ED. From there she was referred to a suburban hospital and subsequently referred to transitional accommodation. Denise was endeavouring to reclaim her home with the assistance of the case managers at the transitional accommodation hostel who linked her up with some legal aid. .Denise was philosophical but shocked and saddened that her sister would do this to her. She had no children. Denise had recently noticed some memory loss which she attributed to her age.

Rose

Rose, aged 52, had been living on the streets of the inner city for the past 18 months. Rose's daughter lived on the streets with her. Rose said she preferred to be independent and stay on the streets rather than staying at families' places because she did not want to be a burden on her extended family. She told of how her day unfolds, sleeping rough in the inner city, how she wakes up from wherever she has found shelter, goes to Tranby's for breakfast, may take a bus to Ruah and then to Beaufort Park for lunch. At the time of interview, Rose said that her handbag had been stolen and she only had the clothes she was wearing and a couple of blankets. She was waiting until she got a new pension card and for pension day, so she could go with her daughter to buy some new clothes from an op shop.

Gwenda

Gwenda, aged 65, a previously registered nurse, recalled her experience of domestic violence, the breakdown of her first marriage and a bitter financial dispute. She remarried but due to financial struggles raising children in a blended family, this marriage also ended. She lived in a rental property but couldn't afford the rent, then moved into her car and then into cheap back packers accommodation. She was living in a short term unit at the time of interview. Gwenda was selling *The Big Issue* which she said supplemented her pension and which helped her both financially and emotionally. She was endeavouring to reconcile with her now grown up children.

Brenda

Brenda, aged 62, was a refugee who fled Uganda and was settled into WA, having lost her parents and her husband in the Ugandan wars. She arrived in Perth 20 years ago with her 4 children (2 boys and 2 girls) and then moved to Queensland with her daughters several years ago. She had recently returned to Perth from Queensland to try and help her sons and their families who were still living in Perth. She was paying her share of rent to her son but unbeknownst to her, the rent was not being paid to the landlord, so all the family was evicted onto the street. She sought help from a multicultural centre who were unable to help her as they told her she'd been in Australia too long. She approached the Salvation Army who referred her to the older women's transitional accommodation. Brenda spoke of how having her parents and husband killed had impacted on her and her children, of how they all had experienced racial abuse since coming to Australia and how all of her children had attempted suicide at some stage. Her strong Christian faith had provided her with a level of coping.

Sarah

Sarah, aged 55, moved to Australia 30 years ago from New Zealand and had 3 children. Her husband became abusive and her relationship broke down. She moved out of the family home and with the support of her parents, managed to raise her children. However, she had untreated bipolar disorder. She left her

children in the care of her parents and borrowed her sister's car in which she slept. She coped financially but was not taking her medication and used her medication money to buy food. While she was living in the car, she was too ashamed to tell her parents and her children where she had gone and so lost touch with them, returned the car to her sister, having decided to go it alone onto the streets. She did not know where to go for help initially but now with the support of the 50 Lives 50 Homes project team, she was renting small a home unit, and has begun to have regular care and support, is back on her prescribed medication. She has reconciled with her family.

5.2 Socio-demographic information

Key findings from some of the socio-demographic information collected are summarised in Table 5.2. In general, the average age was just under 60 years (59.8) with over three quarters having been homeless for over 12 months. While the vast majority were Australian, over 30% were born overseas. Fifty five percent of the women had completed high school education.

The table reflects the circumstances in which women were living at the time of interview including the category of the service where the interview took place; if the women were experiencing homelessness for the first time or had experienced other episodes of homelessness; the duration of their homelessness experience; their country of birth and their race; and their level of education.

Table 5.2 Women's sociodemographic characteristics

General characteristics of the study population (*n*=22)	*N*	% respondents
*Type of homeless service where interviewed interview)		
Accommodation	11	50.0
Comprehensive	7	31.8
Support Service	4	18.2
Stage of homelessness		
First time experiencing homelessness	7	31.8
Chronic / Intermittent homelessness	15	68.2
Duration of homelessness		
< 3 months	2	9.1
3 – 6 months	2	9.1
6 – 12 months	1	4.5
1 – 4.9 years	8	36.4
5 – 9.9 years	3	13.6
> 10 years	6	27.3
Race		
ATSI	7	31.8
Non-ATSI	15	68.2
Country of birth		
Australia*	16	72.7
England	2	9.1
New Zealand**	2	9.1
European	1	4.5
Africa	1	4.5
Highest level of education attained*		
Did not finish primary school	1	4.5
Primary school	3	13.6
Some secondary school	6	27.3
Secondary school	2	9.1
TAFE (or equivalent)	9	40.9
University	1	4.5

*Service Category includes Comprehensive services = wide range of services provided including onsite accommodation, counselling; advocacy; Accommodation = predominately housing services including emergency accommodation; Support services = showers, meals, clothing, no on site accommodation
**Australian born included 7 ATSI women (31.8% interviewees); ***Two NZ born women including one Maori woman, a Bosnian woman who spoke limited English (interviewed via translation service) and one woman who was a refugee from Uganda.

5.3 Family and support networks

A series of questions explored the women's family and social support networks, including their role as a carer for family members or friends. They were also asked about any supports they have in the community including extended family. Their responses are outlined below.

Q5 Can you tell me about your family and support?

Overall, the majority of women (91%) said they currently had some level of family support which was mainly in the form of their children (55 %) or other close family relative (32%) with one (5%) reporting she had a carer who was her former partner. Although she still called him her "carer", he had taken her money and forced her to live on the streets.

Many women said that although they had been close to their family originally, that they had become estranged from their grown-up children throughout their homelessness experience and were in the process of re-connecting, although three still had no contact with their children. Five ATSI women said that they had continued to remain close to their extended family including nieces, nephews and their grandchildren. One (non ATSI) woman said she had recently reconciled with her sister and another (non ATSI) woman with her mother. Two women said they had never had children and had no source of family support (see Table 5.3).

Table 5.3 Sources of family support

Sources of family support (*n*=22)	*N*	% respondents
Children	12	54.5
Close to family	7	31.8
Carer	1	4.5
No living relatives/ or no-one to rely upon	2	9.1
Total	**22**	**100.0**

Q.6 Are you / have you recently been a carer for a family member or friend?

Of the women who had themselves been carers, one had been a formal carer of her grandchildren, one had been a carer for her mother, two had been carers

for their daughters and one had been carer of her ex-husband (many years ago). Two other women specified that although they were not nor had been “carers”, they were endeavouring to provide some level of support from their pensions for their daughters who had terminal cancer.

Q.7 Do you have supports in the community? For example, do you belong to any community groups, have extended family who can help and support you, or others?

Over a third of women reported they belonged to community groups, with almost a quarter (18%) saying they had support from their extended family. These women were all of Aboriginal backgrounds and stated their extended families had helped and supported them.

Women reporting involvement with *Community groups* (36%) consisted of Church groups, The Big issue (2 women) and another who helped in a women’s refuge. Of those who reported support from *Friends* consisted of a woman who spoke no English and a woman who had recently returned from living overseas

The “Other” category consisted of five (23%) women who claimed to have no community support with three others having very limited and/or intermittent engagement with community groups taking those who were socially isolated to over a third. Of the women who said they had no community support, three said they were too embarrassed and ashamed about being homeless to seek any support from their friends; one woman occasionally attended a local community garden; one slept in her car which she sometimes parks on a bush block belonging to a male friend and another attended Alcoholics Anonymous (AA) (see Table 5.4).

Table 5.4 Sources of community support

Types of support (*n*=22)	***n***	**% respondents**
Community groups	8	36.4
Extended family who can help	4	18.2
Friends who help & support	2	9.1
Other	8	36.4
Total	**22**	**100.0**

5.4 Residential history

In order to understand women's residential history a series of questions explored the women's current and previous (three and 12 months prior to interview) living arrangements.

Q8(a) Which of the following best describes your current living arrangements?

At the time of interview, the majority of the women (n=16, 73%) were living in medium-term or transitional housing. Of these, five lived in the single bed units and were awaiting placement in State Housing, 10 women resided in a transitional hostel for older women, and one woman was living in a "safe house".

The other six participants reported a range of living accommodation that included Short term or emergency accommodation sleeping rough (one on the streets and another in her car), staying with local church family and private rental (see Table 5.5).

Table 5.5 Current living arrangements

Type of living arrangement (*n*=22)	*n*	% respondents
Short term/ transitional accommodation	16	72.7
Sleeping rough or in non-conventional accommodation	2	9.1
Short term or emergency accommodation due to lack other options	1	4.5
Private rental	1	4.5
*Other	2	9.1
Total	**22**	**100.0**

* Other incl. one woman living with local church family and one woman temporarily housed in State Housing (no tenure).

Q8(b) What were your current living arrangements 3 months ago?

Compared to their current living accommodation (see Q8(a); Table 5.5), fewer women reported living in *medium-term or transitional accommodation* three months earlier, more reported still being in *private accommodation* or *sleeping rough* with three of the four women in this category sleeping on the streets (see Table 5.6).

Table 5.6 Living arrangements 3 months ago

Types of living arrangements 3 months ago (*n*=22)	*n*	% respondents
Short term/ transitional accommodation	11	50.0
Sleeping rough or in non-conventional accommodation	4	18.2
*Private rental	4	18.2
**Other	3	13.6
Total	**22**	**100.0**

**Private rental* included renting a unit through the "Street to Home Program" whilst other rented with family and friends. ***Other* included a woman at back packers' hostel, one couch surfing (staying with friend but not paying rent) and one living in Indonesia.

Q8(c) Which of the following best describes your current living arrangements 12 months ago?

The range of accommodation settings for these women twelve months prior to the interview was more marked than the settings in which they had lived three months prior and at the time of interview. More women were sleeping rough by living on the streets (23%) or living in their cars (9%).

Women had experienced a diverse range of living arrangements 12 months prior. Five women (23%) had slept rough and another five women had also been living in their own private accommodation (rental and/ or homeowner.) One woman was renting a house in the country but had been airlifted to the Royal Perth Hospital (RPH) Intensive Care Unit (ICU) after being assaulted by her partner, one woman was living in her own home unit and one lived with her husband in Indonesia. Three women (14%) had been living in public or community housing but had been evicted. Two women (9%) had been sleeping in their cars. Two women had been in short term, emergency accommodation and one woman (5%) was couch surfing/ living with friends. Another woman had been living in a caravan park and the remaining woman was residing in a psychiatric care in Perth (see Table 5.7).

Table 5.7 Living arrangements 12 months ago

Women's living arrangements (*n*=22)	*n*	% respondents
Slept rough: no shelter nor accommodation	5	22.7
Your own private rental/ homeowner	5	22.7
Public housing or community housing	3	13.6
Slept in car	2	9.1
Short term, crisis, emergency accommodation for homeless (shelter, refuge, emergency accommodation less 3mths)	2	9.1
Medium term accommodation for homeless (shelter, refuge, emergency accommodation more 3mths)	2	9.1
Living with extended family, friends or acquaintances as nowhere else to live	1	4.5
Temporary accommodation (caravan, hostel, boarding house) slept rough, no shelter or accommodation	1	4.5
Living in a psychiatric care	1	4.5
Total	**22**	**100.0**

5.5 Personal safety concerns

To explore any personal safety concerns, the women were asked a series of questions pertaining to trauma due to domestic and family violence and whilst homeless.

Q9(a) Are you currently or have you ever experienced any violence in your family?

Exposure to domestic violence was reported by over 80% of the women interviewed which consisted of both physical and emotional abuse. Of the 18 women who had reported domestic and family violence (82%), 15 said the perpetrators had been intimate partners (83%). Two women stated that both their fathers and husbands had been physically abusive towards them whilst another two women said their brothers had been violent towards them and one woman said her sister had been violent. One woman said her son had pushed her, but she was reluctant to name this incident as 'family violence' and was recorded as "*Unsure*" (see Table 5.8).

Table 5.8 Experience of domestic and family violence

Experienced domestic and family violence (*n*=22)	*n*	% respondents
Yes	18	81.8
No	3	13.6
Unsure	1	4.5
Total	**22**	**100.0**

Q9(b) Have you been a victim of violence or aggression during the time you have been homeless?

Over half of the women (59%) had experienced violence whilst homeless. Violence was a common occurrence for women experiencing homelessness, with 13 women (59%) saying they had been victims of violence and aggression during the time they had been homeless. Of those reporting violence whilst being homeless, two women stated they had been emotionally and physically abused by their ex partners/ husbands after they moved out of their homes and 11 said they had been kicked, attacked and physically assaulted while they had been living on the streets. This group included three women who said they had been raped while sleeping rough and two of these women said they had been raped *"many times".* One woman said she had been stabbed by another patient while she was in a psychiatric hostel, another who said she was stabbed by a woman in whose house she was couch surfing and one woman still had a restraining order on her son who had chased her with a knife (see Table 5.9).

Table 5.9 Experience of violence or aggression while homeless

Experienced violence while homeless (*n* =22)	*n*	%
Yes	13	59.1
No	8	36.4
*Unsure	1	4.5
Total	**22**	**100.0**

** Included one woman who was living in her car and had been pushed by her son.

Q9(c) Have you needed to seek medical attention / see the doctor or nurse because of physical injuries from domestic abuse? (at home)

Almost half of the women reported they had needed to seek medical attention due to the level of physical injuries from domestic abuse inflicted by their

husbands/ partners whilst they had been living at home, prior to becoming homeless. Three women said they had experienced domestic abuse over a long period of time and had needed to seek medical assistance many times. Two women had been hospitalized as a result of being severely beaten.

It is noteworthy that "No" also included women who said they had needed medical care but were unable to access it. One of these women reported she had not sought medical attention for her injuries as she had been too afraid as her husband had threatened to kill her if she went to the doctor. Similarly, another woman said she did not seek medical attention because of family implications if she reported that her brother had assaulted her (see Table 5.10).

Table 5.10 Need for medical attention due to physical injuries from domestic abuse when living at home

Needed medical attention sustained from domestic abuse when living at home (*n*=22)	***N***	**%respondents**
Yes	10	45.5
No	11	50.0
*Unsure	1	4.5
Total	**22**	**100.0**

**Unsure* included one woman whose partner had stalked her after they had separated and subsequently returned to the home they had been sharing and assaulted her.

Q9(d) Have you needed to seek medical attention / see the doctor or nurse because of physical injuries from domestic abuse? (when homeless)

Nearly a third of the women interviewed said that they needed to seek medical attention due to physical injuries while being homeless. Most of these incidents had occurred prior to the women becoming homeless, but they required ongoing medical treatment. Seven women still required medical attention due to previous injuries and trauma (32%). These included one woman with depression, two with PTSD resulting from previous abuse, one woman with tinnitus from an old head injury after being beaten by husband, one woman with Acquired Brain Injury who had ongoing headaches and memory loss and one woman who had lost her eye due to a beating and one woman who had been kicked in her ribs by her son while sleeping rough in her car (see Table 5.11).

Table 5.11 Need for medical attention for physical injuries due to abuse when homeless

Requiring medical attention due to DV (*n*=22)	*N*	% respondents
Yes	7	31.8
No	14	63.6
*Unsure	1	4.5
Total	**22**	**100.0**

* Included one woman who was experiencing ongoing mental health problems and *"flashbacks"* after partner abuse.

Q9(e) Have you experienced any other trauma (e.g. accident, street violence)

Over half of the women (55%) stated that they had not experienced any other trauma outside family violence whilst they had been homeless. Of those reporting that they had, one included a woman who had fallen over in a shop, one woman had fallen out of bed in hostel, three women had been raped/sexually assaulted while living on the streets (with one saying she had subsequently contracted HIV), and one woman said she had been "kicked" in the street (see Table 5.12).

Table 5.12 Women's experience of other trauma when homeless

Other trauma experienced when homeless (*n*=22)	*N*	% respondents
Yes	7	31.8
No	12	54.5
*Unsure	3	13.6
Total	22	100.0

* Included one woman who was worried about being stalked by her ex-partner, one who had been assaulted by her brother and one woman said she was "*trying to put it out of her mind*" (but was reluctant to specify what had happened to her).

5.6 Self-reported health status

Women were asked to describe their perceptions of their current and previous health, their current health conditions and the healthcare services they had utilised since they became homeless.

Q10(a) In general, how would you describe your current health?

The majority of the women interviewed reported their current health as fair to very poor (73%). For the two women who reported their health was *Very poor*, one woman suffered PTSD from childhood abuse and had recently was back

living on the streets and the other woman had developed Lupus Erythematosus and PTSD prior to becoming homeless and continued suffer from these conditions (see Table 5.13).

Table 5.13 Current health of women

Perceived current health status (*n*=22)	*N*	% respondents
Very good	2	9.1
Good	4	18.2
Fair	8	36.4
Poor	6	27.3
Very poor	2	9.1
Total	**22**	**100.0**

Most women indicated that their current health was about the same as a year ago (59%) with a further six women saying their health was much better / somewhat better since finding somewhere safe and secure to live (27%).

Q10(b) How does your current health compare to that of a year ago?

Of those reporting reduced current health status compared to a year ago, one example was of a participant who suffered from a previous head injury and was currently experiencing headaches potentially due to a 3cm blood clot on her brain (somewhat worse). Two women who had been recently seriously physically assaulted on the streets (one of whom had been sexually assaulted) reported their health was much worse (see Table 5.14).

Table 5.14 Self-reported current health compared to one year ago

Perceived health status (*n*=22)	*N*	% respondents
Much better	3	13.6
Somewhat better	3	13.6
About the same	13	59.1
Somewhat worse	1	4.5
Much worse	2	9.1
Total	**22**	**100.0**

Q10(c) Do you currently or have you ever suffered from any of the following?

By far, the most common health concern related to *injuries and trauma* (86%) and included injuries sustained assaults from husbands/ partners included head injuries, nose and ribs, tinnitus, brain damage.

The second most prevalent health concerns were Co*nditions of the ears, eyes, nose and throat* (82.%), and included ear infections, hearing problems, tinnitus and vertigo due to from previous injuries, eye/ vision problems and needing spectacles, damaged eyes from beatings.

Almost three quarters (74.%) of the women reported that they had suffered from or currently experienced depression, with half also reporting they suffered from other mental health conditions. These conditions included grief, bi-polar disorders, generalised anxiety disorders and stress relating to their homelessness, particularly for those women who had experienced living on the streets. Most of the women who indicated they had mental health concerns also said they had depression, for which they took prescribed medications / anti-depressants. Sleeping problems and fatigue were experienced by 73 % women. Chronic pain included back pain, degenerative back conditions, joint pain and pain caused by arthritis. Digestive disorders included stress related digestive problems, gastric disorders due to living on the streets and only able to access prepared food; constipation due to the side effects of medication (see Table 5.15).

Table 5.15 Current and previous health conditions and concerns (multiple responses)

Current and previous health concerns (*n*=22)	*N*	%
Injuries and Trauma	19	86.4
Conditions of the Ears, Eyes, Nose and Throat	18	81.8
Depression	16	72.7
Sleeping Problems	16	72.7
Fatigue	16	72.7
Dental/ Teeth Problems	16	72.7
Chronic Pain	13	59.1
Arthritis or Joint Disease	13	59.1
Other Mental Health Concerns	11	50.0
*Women's Health Problems	10	45.5
Alcohol and Drug Use Problems	9	40.9
Diabetes	9	40.9
Lung Problems/ Asthma	6	37.5
Stomach/ Digestive Disorders	8	36.4
Osteoporosis or Bone Disease	7	31.8
Bladder Problems	7	31.8
Heart Disease	6	27.3
Skin Conditions	5	22.7
Liver Disease	3	14.3
Cancer	2	9.1
** Other	2	4.5

*Women's Health Problems included seven women with peri/ post-menopausal problems including vaginal bleeding and hot flushes, one women with a breast problem, two women with abnormal Pap smears ; one woman with STD; **other included one women with epilepsy and one woman who was HIV positive.

Q10(d) What is you most significant health disorder, and where do you go to get care for it? (open ended question)

The women were asked to nominate their <u>most</u> significant health condition disorder and where they seek treatment. Seven women (32%) nominated a **serious other* health condition. This consisted of four women who were still suffering with problems attributed to their Acquired Brain Injury (ABI) including one woman with dizziness and headaches, one woman with a 3 cm blood clot detected on ultrasound, one woman continuing with rehabilitation sessions after being air-lifted to ICU after an assault, and one woman with balance problems and falls due to ABI from a head injury due to being physically assaulted by her former husband. The three other most significant serious health conditions

included one woman with Lupus Erythematosus with an associated fibromyalgia, one woman who had a Cerebral Vascular Accident (CVA) some years ago and still dribbles a little, and one woman who was HIV positive and is receiving ongoing management.

The second largest category of current concerns nominated by the women related to their mental health concerns, with five women (23%) reporting depression and anxiety. These women said they visited a GP to prescribe their anti-depressant medication and/or attended regular counselling sessions with a psychologist (see Table 5.16).

Table 5.16 Most significant current health condition

Current health condition (*n*=22)	*N*	% respondents
*Serious 'other'	7	31.8
Mental health concerns	5	22.7
*Other	4	18.2
Chronic pain	2	9.1
Circulatory problems	2	9.1
Diabetes	2	9.1
Total	**22**	**100.0**

* Included bladder, lung, skin, sleeping problems

5.7 Health service utilisation during homelessness

Q11 Have you used any of the following healthcare services since you became homeless? (Multiple responses were allowed)

The women reported accessing a wide range of health services since becoming homeless. GP/ doctor services were the most common health services they had utilised (76%), especially when considered with Mobile GP services (32%). Only nine women reported they had utilised Hospital Emergency Departments (43%), although half of the women said they had utilised hospital services (50%).

Counselling services were used by many of the women including psychological counselling (55%); general counselling (55%); and sexual assault counselling (27%). Eight women said they had accessed mental health services (36%).

Allied Health and dental services were commonly used by the women, with eleven who said they had had also accessed dental services (50%) and seven women had used Allied Health Services (35%).

Those women who said they had accessed culturally specific services included two ATSI women, one woman from Croatia who spoke virtually no English and one woman from Uganda.

Two women said they had utilised Women's Health Services. This comprised one woman who had visited Women's Health and Family Services in Northbridge and one woman who had visited the Women's Business Clinic in Kalgoorlie prior to her moving to Perth. Many of the women commented that they were unaware of women's health services but would have used the services if they had known of their existence and whereabouts (see Table 5.17).

Table 5.17 Healthcare providers since homeless (multiple responses)

Healthcare Services Used Since the Women Became Homeless (*n*=22)	*N*	% respondents
GP/ Doctor	16	72.7
Counselling (Psychological)	12	54.5
Counselling (General)	12	54.5
Hospital	11	50.0
Dentist	11	50.0
Emergency Dept.	9	40.1
Mental Health Services	8	36.4
Allied Health	7	31.8
Mobile GP Service/ Street Doctor	7	31.8
Counselling (Sexual Assault)	6	27.3
Alcohol and Other Drugs Services	5	22.7
Culturally Specific Services	4	18.2
Women's Health Services	3	13.6

5.8 Summary of key findings

The age of the women interviewed ranged 50 to 82 years, with the average age of 59.8 years. Over 75% had been homeless for at least 12 months. Most of the women were currently living in transitional or untenured accommodation but two women were living on the streets and one slept in her car. Although most

of the women said they now had some level of family support, many had been estranged and were currently reconciling and with the support of homeless services. Exposure to family violence was reported by 82% of the women and four women had residual ABI from beatings from former male partners. Over half (59%) had experienced violence and trauma whilst homeless. The majority of the women also reported their health was “fair” to “very poor” and that their health was about the same as a year ago. The most women’s common health concern related to injuries and trauma (86%). Their physical health conditions included eye and ear problems (including vision and hearing), chronic pain, arthritis, joint diseases and diabetes. 73% women said they had dental problems. Half of the women indicated they had mental health concerns, 73% saying they had suffered from or were suffering from depression. Sleeping problems and fatigue were also experienced by 73%. The women reported using a range of health services since becoming homeless, with GP/ doctor services (73%) the most common health service. Over half of the women had accessed both mental health and general counselling services and 50% had accessed hospital services with 43% accessing hospital EDs.

The key findings of the survey and their relationship to the critical literature including their demographic history, self-identified health needs, the factors that had contributed to their to homelessness; domestic violence and the impact of the social determinants of health will be discussed in Chapter 9. The information provided in the following Chapters 6 and 7 provides results from the semi structured interviews that explored some of these issues in greater detail.

While every attempt was made to select from a diverse group, the sample of women is not fully representative which could impact the generalisability of the study to the wider population of older women experiencing homelessness and other homeless populations.

Chapter 6
Interview Results

This chapter describes the responses from the semi-structured interviews undertaken with women, SHSPs and healthcare providers, and provides an overview of the major themes that evolved from the analysis of the responses. The semi-structured interviews with women follows on from their completion of the women's surveys as described in Chapter 5. The interviews sought to address the following research questions:

- What do the women see as their primary/ predominate healthcare needs?
- What factors influence the women's ability to access healthcare services to improve their health?
- What actions could be undertaken to help improve the health and wellbeing of older homeless women?

As outlined in Sections 3.4.7, 3.4.8 and 3.4.9, 22 women with experience of homelessness, eight specialist homelessness services staff and eight healthcare provider staff were interviewed using a semi structured interview technique. The questions asked of all three groups covered the same topics but were modified to reflect their different perspectives (see Appendix J, Appendix Q, and Appendix S). The interviews explored the health needs of older women experiencing homelessness; how health influences and is impacted on by their becoming homeless and to determine if current health services are adequately addressing their needs from the perspectives of the three groups.

The women shared their experiences of homelessness, including duration, recently, the reasons they had become homeless and how these factors had impacted on their health. The women also spoke about what they considered was important in maintaining their health and wellbeing, including how their overall personal security and safety had affected their health. They also spoke of the personal difficulties they had faced and shared some of the strategies they had adopted to help them cope as they endeavored to transition into the future.

The SHSP and healthcare providers were asked to share their perspectives and understanding of how the homelessness experience had impacted the health needs of older women accessing their services. This included perspectives on the contributing factors to women becoming homeless and the recency and duration of their homelessness. Providers were also asked to comment on their perceptions of adequacy of health services for older homeless women in the Perth metropolitan area.

The eight interviewees from seven key SHSP organisations included five service managers and three case workers. The eight healthcare provider interviewees included three medical practitioners, three nurses, one psychologist and one healthcare adviser. All the SHSP and healthcare providers had extensive experience in working with people experiencing homelessness, including older women.

6.1 Development of themes

The choice of Qualitative Descriptive as the methodology for the qualitative component requires a descriptive (framework) thematic analysis. Template thematic analysis uses a priori code frames to analyse and report on the data. 'Themes' are features of participants' accounts characterising particular perceptions and/or experiences that the researcher sees as relevant to the research question. As described in Section 3.4.10.2 , the information obtained from the women's interviews were transcribed before being thematically analysed into major themes. Although the questions asked of the SHSP and healthcare providers were very similar to those asked of the women, theme development was based solely on the responses provided by the women. Interview responses from the SHSP and healthcare providers were also examined and used to support and provide greater insights to the detail emerging from the women's responses (see Appendix M).

The following sections illustrate the process that was used for all the themes but based on direct feedback to questions that lead to the identification of the major theme – "financial security".

6.1.1 Example of theme identification – financial security

Although none of the interview questions directly asked about financial issues, this issue was seen by the women and the various providers as a key element of both the women's circumstances and integral to their health state.

Questions, interviewee responses, codes which led to the financial security theme:

Women's response:

Q1 "What does it mean to be healthy?"

"So, that's your physical health. Your emotional health. Your mental health. Your spiritual health. And your financial health as well." (→ Code: managing financial needs)

Q2 "What would you say are your main health needs now?"

"Increase the pension" (homeless woman who had been evicted from her home and was struggling to pay for medications) (→ Code: financial impact, accessing financial support)

Q3 "Tell me about your experience of homelessness?"

"I always had an income, and this would be the first time that I found I just couldn't turn around and get that help." (→ Code: financial impact, applying for social security)

"Your stuff gets pinched ALL the time… I'm constantly replacing medications and clothes and just everything I own …having to replace it all the time, so it ends up costing you more that it would if you were actually paying rent and had somewhere you could keep everything safe." (→ Code: managing financial needs, lost stolen ID, applying for social security)

Q4 "If you think about homelessness, would you say this has positively or negatively affected your health (if so, in what way)?"

"During my second divorce, my husband left me half a house, like a house with a mortgage. And I tried to manage, but I couldn't…my car blew up, so I had to borrow, and the bank wouldn't let me borrow more money for my car, so I had to sell that house and I bought another one.

And I had started to drink a bit heavily, but the government took my kids away." (→ Code: financial impact, causes distress)

"Well, I would be healthy if it wasn't for, when my sister embezzled my home unit overlooking the water in South Perth…I used some of my pension to stay at hostels, so it's $30 a night." (82-year-old homeless woman who was taken to RPH by backpacker accommodation staff after a dizzy spell) → Code: financial impact)

Q7 "Has anything prevented you from receiving the health services you needed?"

"Nothing – no social security, no healthcare card – nothing. I have no money. Thank god for the Salvation Army." (woman who received support from the Salvation Army after arriving in Australia from New Zealand and still has no access to social security) → Code: financial impact, social security)

"Yes. The cost. The cost." (→ Code: financial impact)

Q9 "Would you say this service (where interview taking place) been able to help you access the health services you need?"

"Five smiles for the dentist at St Pat's and the Street Doctor…they also provide a lot of the medications you need for free." (Woman who had used the free dental and Freo Street Doctor services at St Pat's), → Code: managing financial needs sub theme managing financial needs to maintain health)

"The best thing you could do for women, like me, who are not well, who don't speak English, who actually are lost here, to give them pension, maybe not the whole, but just a part and…and send them back home." (Homeless Croatian woman) → Code: financial impact, accessing financial support, social security).

SHSP and healthcare providers:

Q1 "What are the health needs of older women who are experiencing homelessness?"

"Most of the women have a constant stress about how they're managing financially…asking for help can be a bit difficult because they think they should be able to manage." (Psychologist → Code: financial impact, accessing financial support, social security).

Q2 "How the women's experience of being homeless has impacted on their health needs and their experiences of health services?"

"Because they've had a relationship breakdown…and they've lost their income, because their spouse has been the main income earner, or their spouse has died...and suddenly they've lost that income." (nurse), → Code: financial impact, accessing financial support, social security)

"It's actually the financial component that really hasn't been highlighted by the individual, but it's there… it's all around the trauma or the assault or whatever the cause but it becomes financial… Women who are poor have more health issues because of their stress… then they become homeless and it increases their stress." (SHSP manager) → Code: financial impact, accessing financial support, social security).

Q3 "What are the barriers and enablers to accessing healthcare for these women?"

"Cost is a barrier." (SHSP manager) → Code: financial impact)

Q4 "*Are* current health services addressing the health needs of this population?"

"There's a gap, and there's only ten sessions, and some of these women have very complex issues." (Healthcare provider discussing how although women can obtain a mental health plan from the GP for 10 free sessions with a psychologist, they need to find a bulk billing provider otherwise they are faced with paying a gap fee of at least $40, → Code: financial impact).

6.1.2 Codes and sub-themes

Drawing on the responses to the questions listed above, thematic analysis revealed a number of key words and short phrases that referred to women's concerns about cost, finances, income, social security had been frequently raised by participants throughout the interviews and reflected in the transcripts. These words and phrases were highlighted and categorised by a number of codes:

An iterative process of refining assignment of quotes to the codes and the grouping of these into sub-themes ultimately lead to the identification of the major themes that captured the key essence of the interview conversations. Once all the data had been comprehensively coded into sub-categories, the researcher refined the codes into sub-themes and possible themes (see Table 6.1).

Table 6.1 Grouping of codes into sub-themes

Codes	Sub-themes
Financial impact Managing financial needs Accessing financial support	Managing financial needs to maintain health
Applying for Centrelink support Lost / stolen ID Social security	Impact of financial insecurity – causes distress

This process was undertaken until a final nine themes emerged from the process. Other than the theme 'Financial security' outlined above, the other eight themes uncovered are shown in Table 6.2.

The iterative process that was utilised to organise and group quotes from the transcribed interviews into sub-themes and ultimately into the nine major themes is shown in Appendix L and outlined in the table below:

Table 6.2 Major themes and elements of their construction.

Major-theme	Sub-theme	Codes
Accommodation and safety	Accommodation housing Accessing homelessness services Awareness of services	Safe accommodation fundamental to health Somewhere safe to sleep Safety and security Home environment Keeping food safe Health effect of risk of homelessness Getting older
Women's experience of trauma and abuse	Past trauma impact on health Trauma since becoming homeless	Family/ domestic violence Not knowing what to do/ who to turn to Physical injury ABI Sexual abuse – harassment
Impact on a woman's health due to her inability to fulfil her role as family nurturer	Children family Family impact Family counselling	Children, grandchildren Grief and loss of home and family Estranged / disconnected
Mental health needs	Mental health needs Role Alcohol and AOD Fatigue and sleep Mental health services	Mental Grief, loss Impact trauma PTSD Anxiety Depressed

Major-theme	Sub-theme	Codes
		Female psychologist/ psychiatrist need
Complex interaction of physical and mental health needs	Physical health needs	Chronic health
	Lifestyle and preventive health	Diabetes
	Women's health specific needs	Muscular-skeletal pain - Arthritis
	Inter-relationship of health & homelessness	Headaches / ABI
	Mental health	Immune system
	Role of AOD in Mental Health Mental health services	Getting older
		Menopause
		Sleep/ insomnia
		Medications
		Mental health
		Health related cause of homeless
Stigma, shame, embarrassment and fear of being judged	Previous negative experience with health system	Too embarrassed about homeless situation and mental health to ask GP for help
	Staff understanding, attitudes, communication and non-judgemental approach	Embarrassed to tell family & friends about homeless situation
	Ethnic and culturally specific services	Stigma of being homeless at hospitals GP pharmacist
		Stigma drugs
		Stigma of being an older woman who has become homeless
		Reluctant /scared ask for help
		Confidentiality concerns
		Staff judgment and understanding
Costs of healthcare services and pharmaceuticals	Affordability	Cost medications
	Cost barrier	Access to bulk billing GP and specialists
	Medications	Dental
	Access to Allied Health providers (including Dental)	Cost of getting to specialists
	Access to Medical Specialists	
Need for ongoing psychosocial and healthcare support once housed	Older women specific needs	Vulnerable - long time
	Planning for the future	Need further support while housed transitionally and beyond
	Cooperation and links between providers	Social support
		Value access same doctor
		Staff help access Centrelink
		Staff help access longer term housing
		Staff help access ongoing medical
		Value achieving good mental health
		Planning for future

6.2 Major themes

A number of themes emerged from the results of interviews which highlighted the complexity of women's experience of homelessness and inter-related nature of their homelessness and their health needs. The themes are presented in the following headings:

- accommodation and safety
- women's experience of trauma and abuse
- impact in health an inability to fulfil women's role as family nurturer
- mental health
- complex interaction of physical and mental health needs
- stigma, shame and embarrassment and fear of being judged
- financial security
- cost of healthcare services and pharmaceuticals
- the need for ongoing psychosocial and healthcare support once housed.

6.2.1 Accommodation and safety

The issue of accommodation and safety arose in many contexts during the interviews with the women. This included the need for housing to address their homelessness, but also concerns about personal safety, store food and other personal items and a place to maintain relationships with family members and their friends. All women stated that their main health priority was having somewhere safe, secure and stable in which to live.

6.2.1.1 Perspectives of the women participants

Regardless of their current living circumstances, having safe and secure accommodation was the women's predominate health need. When prompted to explain what they meant the researcher received comments like: *"a proper home environment to live in … in a place where I can rest, sleep and relax"…. "something a bit more permanent"*, *"stable accommodation, a kitchen, like my kitchen and just my own space."* One woman said that for her, healthy meant having a place to live where she could have a *"decent home cooked meal, in a place where I can rest sleep and relax". "If you feel safe and secure, you can feel well within yourself too.*

It makes you feel well. Improve. Makes your mental health better". Another woman said that being able to stay in transitional accommodation was a *"healing… "I've got what's important now I feel so warm with security"* whilst another said she had noticed since she had returned to living on the streets after moving out of a women's safe house, her health had deteriorated.

Women had noticed that the various places in which they had lived since becoming homeless, and how long they had been living there, had affected their health. One woman who had mostly stayed in back packer hostels and had also 'slept rough' stressed spoke of her fear at night on the streets *"it's really unsafe out there at night."* The women highlighted that they needed a place to live, to store their possessions and food. A participant who was 'sleeping rough' (sometimes in her car, sometimes in the street) explained that *"your stuff gets pinched ALL the time… I'm constantly replacing medications and clothes and just everything I own …having to replace it all the time, so it ends up costing you more that it would if you were actually paying rent and had somewhere you could keep everything safe."* Women with diabetes stressed their need for accommodation in order to store their food and medication to maintain their blood sugar levels. As one woman said, *"for me it's having a home – having a fridge and a stove … you know just the basics that people would take for granted…the most important things because without that I can't control my diabetes for a start, which is not helping my other health issues."* Another woman whose diabetes had become worse by impacting on her food choices and availability thereof said … *"being homeless… you've not got a fridge that you can store anything in …so you can't go out and get fresh fruit and vegies and stuff every day."*

Women sought to have regular contact with their families and finding long term accommodation was a priority for many women who wanted their grandchildren to come and visit them. Being healthy to one woman meant having *"a full day with my family."*

Several women said they felt that not having a safe and stable place to live, combined with their getting older, had worsened their previous health problems, particularly increasing their need for medication for insomnia and for pain due to musculoskeletal problems. Their deteriorating health was often compounded by

their being embarrassed and ashamed to admit they were homeless, which in turn made them reluctant to seek help *"at your age everybody expects you to be on top of your game, have your own home so at 62, asking for accommodation saying you're homeless it's very, very demoralising…very embarrassing."*

Participants sleeping on the streets said it was dangerous and *"very rough",* speaking of how they try sleep in the park during the day for safety and then try find a place like a house with a veranda and out of the way at night where they can sleep, then get up and get moving early in the morning.

6.2.1.2 SHSP Perspectives

All SHSP unanimously agreed that the women's need for stable and safe accommodation was fundamental to their health and wellbeing. *"There's the grave threat of becoming homeless, the focus is on accommodation, and obviously, there's a heightening of stress, anxiety, everything falls apart … health, mental health, so people's well-being is acutely affected with the risk of homelessness or being homeless…the minute you've got stable accommodation the health improves.*" (SHSP manager).

Women's health needs are exacerbated by not having a safe place to live and that older women sleeping rough are highly anxious and constantly looking out for their personal safety. *"Health needs are a low priority for women who don't have accommodation, you don't have food, you don't have shelter and don't have somewhere safe to sleep. When it comes to managing their diabetes, or their chronic health, it's not a high priority when you need somewhere to sleep."* (SHSP manager).

SHSP had observed that as people age, their health needs generally increase, and if they're at risk of homelessness or actually become homeless, those health needs increase *"exponentially."* For women being seen at a community homeless centre, their health needs become more acute as they age and finding somewhere to stay becomes a higher priority for these women than their managing their chronic health needs. SHSP had found that many of the older women seen at the centre had poor coping skills, that the impact of

homelessness had thrown them into chaos, and they required additional assistance to manage their medications.

Interviewees expressed their concern for the vulnerability of women sleeping rough/ living on the streets as they are exposed to physical and sexual assaults, as well as muggings. Several providers stressed these women were "*easy bait*", had to be highly vigilant all the time as they were in danger. One provider pointed out that women feel safer in a car than under a tree or living in an untenable relationship but noted that women sleeping in their cars can accumulate multiple parking fines which they are unable to pay and may end up in prison because of unpaid fines.

6.2.1.3 Healthcare providers' perspectives

Many healthcare providers reported the importance of accommodation and safety as fundamental to the health needs of people experiencing homelessness, including older women. "*Your health needs are very low on the priority if you don't have somewhere safe to sleep. If you don't have shelter. If you don't have food. If you don't have accommodation"* (nurse). A medical practitioner who had worked extensively with homeless people said that from his experience, he had observed that once people are housed their anxiety is reduced and they feel better instantly. However, as he and the other health providers had observed, the women required ongoing support as they settle into accommodation, as often other issues can emerge, particularly relating to previous trauma and many become depressed after their initial anxiety settles.

Health providers also spoke of how many of the women, especially rough sleepers, only present when their main health needs are severely run down, have not had any comprehensive care for a long time, may present to ED to get treatment. They present late to the acute system, and the tendency is that they wait until they are really sick or until they collapse and someone else calls the ambulance. Many have chronic illness, have had previous poor experiences with the health system which compounds their reluctance to present for health needs until they are really ill. *"Your health gets left to the wayside when you are homeless, it's your last priority… people don't come and see us unless they are very sick and for the majority their health status is generally poor"* (nurse).

Healthcare providers also reported that older homeless women also had to deal with health issues related to aging, such as osteoarthritis and dementia. A psychologist spoke of women who experienced flashbacks of suppressed trauma that they had managed to put aside but as they get older, are starting to remember. She spoke of a woman in her seventies who was now vulnerably housed and who was experiencing flashbacks to the trauma and violence from which she had escaped many years ago, and explained *"it's sexual abuse, and domestic violence, wherever your life's threatened, those things come back to people, particularly after 70…. in this horrible situation, grovelling for food, having to go to the op shop, scared that they're going to get attacked at night".*

6.2.2 Experiences of trauma and abuse

The interviews with older, homeless women revealed the level of family violence, abuse and trauma that most of them had experienced during the course of their lives. Many of the women had escaped domestic violence and continued to recall their previous experience of trauma and abuse which impacted on their physical and mental well-being, and their ability to engage with male healthcare staff. Those women who were sleeping rough remained at risk of further trauma and abuse. The women reiterated that their safety was a major health priority. Providers highlighted that the nature and length of time that a woman had experienced trauma and abuse prior to becoming homeless contributed significantly to her current mental health.

6.2.2.1 Perspectives of the women participants

Virtually all the women interviewed had experienced some form of family violence, abuse and trauma which had included physical, emotional and financial abuse. "*I had a very difficult life with my husband, my life was hell with him, he wouldn't let me leave the house"* (woman now living in transitional housing). Another woman who still experiences trauma spoke of her experience: *"I have the memories and the flashback of the bashings all the time". Se*veral spoke of their shock of not knowing what to do, who to turn to. *"You know, I had a pretty protected up bringing …never sort of came across these sort of problems with my ex-husband, so I didn't know how to deal with it."* The women felt their

experience of trauma before they became homeless still affected them, with many of the women speaking of how they had experienced further trauma during the time they had been homeless, including having been sexually assaulted while sleeping rough. One woman shared her experience and still blamed herself after being sexually assaulted while living on the streets. *"I blame myself because I was putting myself in that situation. I put myself in a lot of dangerous situations, and around a lot of dangerous people."*

6.2.2.2 SHSP perspectives

For many of the women who were using SHSP services, domestic violence and assault were common contributing factors to their becoming homeless. Several SHSP interviewees working with women who had experienced abuse and had left their partner due to violence suggested that the length of time and extent of trauma inflicted prior to women becoming homeless had a greater impact on their health than the actual length of time they were homeless. A case worker had observed in older women who had become recently homeless, that they had become homeless often after a long period of stress and trauma. She spoke of how these women were often physically and mentally unwell, their health had been compromised by the burden of not having stable accommodation and then they became homeless which further exacerbated their health.

Interviewees from every SHSP participating in the study spoke of the significant and pervasive impact of domestic violence (including physical assault and head injuries and mental abuse) on the health of the women utilising their services. *"Most of the women that we see coming through have experienced violence either during their times on the streets, or the domestic violence led them to becoming homeless in the first place … we've seen older women come through that."*

They also spoke of how once the women were housed, they often regressed back to the situation and had flashbacks of the beatings. One case worker said she had seen a lot of women with sutured injuries, facial injuries, acquired brain injuries, black eyes. She also explained the impact of psychological abuse. *"A lot of women don't talk about it until it's too late, and then they're so far down the ladder that it takes a long time to pick yourself up again … way down… it's a huge*

problem most of our women don't have bruises and things… they don't go out and see their friends, they don't do so many things and when this all breaks down,…women who are victims of violence…I think their mental health is because of that violence."

Another case worker who was helping a woman who had been seriously assaulted resulting in several weeks in RPH intensive care due to head and brain injuries, months of rehabilitation at a tertiary hospital. The woman was unable to remember the incident and the worker told me: *"it's a good thing she doesn't remember at this point… but when she does… I can't imagine what that's going to be like for her… we're getting as much support around her as possible…to build up her emotional capacity to cope, and resources in case ... of that event happening."*

6.2.2.3 Healthcare providers' perspectives

Nurses spoke of how they are starting to see a few women who are surfacing now who were actually unable to maintain housing… *"once you get to know them, there's all these layers... there is trauma in the background. There are histories".* A nurse said from her experience, she believed that trauma was the major health precursor to becoming homeless *"I don't think we'd be exaggerating if upwards of 90% of people we see have some trauma that has either happened since being homeless or has led to them being homeless…or both."*

A medical practitioner had observed that the health needs of women seen in ED were often related to physical trauma and being assaulted by their partners saying …*"because quite a number of those women, in order to stay safe will partner with men who are able to protect them, but are often the most aggressive and violent men, which makes them good protectors, but it also means that they are at high risk of abuse from those men, so we see quite a number where the women are regularly assaulted by their partners*." She added that women are also being assaulted on the streets, often directly related to drug and alcohol and that the longer the woman was homeless, the longer the time she could be traumatised (due to being beaten, have her possessions stolen, and/or be sexually assaulted).

One nurse had also observed *"because they're so naïve, and vulnerable, and desperate for someone to look after them, that vulnerability means that they're easily taken advantage of… and they want to trust somebody ... and so they do, and that might be fine for a couple of days, and then it turns into… something else… abuse."*

A nurse working with the Homeless HealthCare (HHC) team and a medical practitioner working with the mobile street doctor services noted that some women they see, may have initially experienced trauma and domestic violence 10 to 15 years earlier and this continues to impact on the women. The medical practitioner had observed *"there is usually some trauma that has either happened since becoming homeless or led them to being homeless …there's all these layers…and there is trauma in the background."*

6.2.3 Impact on health of perceived inability to fulfil women's role as family nurturer

Many of the women had become estranged from their families through family conflict and embarrassment about being homeless and reported the level of distress this caused them. Their need to regain a connection and continue to engage with their children and grandchildren was integral to their physical and mental recovery and ongoing health status. Both the SHSP and healthcare providers said they had consistently observed the women's anguish at losing connection with their family and where possible endeavoured to support their reconciliation.

6.2.3.1 Perspectives of the women participants

Many of the women were estranged from their families which distressed them greatly. For others, although they themselves were in dire circumstances, they continued to try to assist their now grown up children who were experiencing hardship and, in some cases, terminally ill. One woman who lived on the streets with her 30-year-old daughter, said she still felt responsible for her daughter.

Overwhelmingly, the women cited their relationship with their families, particularly their children and grandchildren as crucial to their health and well-being, *"One of the things about homelessness …is not having a home for my*

children and grandchildren." An Aboriginal woman said, *"I'm family orientated. Most Aboriginal people are, because they've had a lot to do with their grannies...it's important, the grandmother's role, it's always part of you. You always worry where they are, what they're doing."* She said her main reason to try to be healthy was *"as I grow older, I'm healthier for my grandchildren."*

Struggling to cope with their relationship family breakdown and the associate d trauma, some women said that with the assistance of SHSP, they were now were reconciling with their families and how maintaining regular contact with their family was important for their emotional health. Another woman told of re-connecting after several years with her daughter and her mother (whom she had been too embarrassed to tell she was sleeping rough) had helped her to become mentally healthier. Several women spoke of how family key events, particularly Christmas, had triggered distress for them.

6.2.3.2 SHSP Perspectives

All providers consistently commented on women's estrangement from family, from children and how painful this was for the women, and of how the women were *"always worried about their children."*

Some spoke of the women's/ mother's guilt, embarrassment and shame of becoming homeless, of how many of the women hid their homelessness from their children and became disconnected. Then, in the process of seeking health and housing support, they also sought the help of the case workers to get re-connected with their children … *"that's another wound they walk around with, that they've lost their children, or they've let their children down."*

One case worker explained that Christmas time was often a very painful and explosive time for the women as it brings up all the past, as do any sort of anniversaries and providers see *"invariably a trigger of alcohol use, drug use, death, people overdosing at those times."*

One of the case workers at a women's domestic violence refuge had noticed an increasing number of grandmothers coming into the refuge as the mothers have been placed in psychiatric care due to mental health issues resulting from heavy drug use *"the grandmas come in here because they get involved in their*

horrendous domestic violence, and their children's violence, and it's aimed at the grandparents, and-so we end up having grandmothers in here with children."

A SHSP manager recounted some positive stories by whereby many of their residents over the previous 12 months period have reunited with sons and daughters, and families. She spoke of one woman, who after she moved into transitional accommodation, had started to meet her son more often "*then started to cook for her son, and the son supported her, and the son is positive to the extent that he even offered to be a volunteer."*

6.2.3.3 Healthcare providers' perspectives

A medical practitioner observed that the loss of family is a key issue for women, noting lost contact with their children occurred for a range of reasons, including the placement of children of their now grown children under protective care, their (now grown) children having moved for work, children (and grown children) with drug and alcohol problems...*"especially in Aboriginal older ladies, because they are supposed to be the role model and the aunty or central person to the family. And they're not that person anymore."*

Providers had found that sometimes women (from all cultures) are embarrassed to ask their family for assistance, sometimes their family don't know they're in hospital. "*I think the thing is traditionally the women has been the person that keeps everyone else going. You see women in the park, they are still going around providing that nurturing, supporting other people. Even though they might not be family. They're family in a different way"* (nurse).

Healthcare providers spoke of how most of the women have to deal with grief and loss, and estrangement from family, some of which occurred recently but often happened over many years. They had observed that women use sedation and tranquillisers to numb their stress and despair at being separated from their children.

6.2.4 Mental health issues

A majority of the women interviewed had pre-existing mental health concerns that were exacerbated by their homelessness. While the underlying causes of

this were wide and varied, the impact of the condition persisted in those who managed to find long term accommodation, but in some cases, also contributed to them becoming homeless once again. Providers reported that most of the women experienced some mental illness including anxiety and depression. Another observation they made was the re-emergence of suppressed trauma once the women had been settled into safe accommodation.

6.2.4.1 Perspectives of the women participants

Many of the women participants had major mental health concerns which they experienced prior to the outset of their homelessness or had developed as they spiralled into worsening circumstances. Although many of the women were now in transitional accommodation, they said mental health remained their main health need. Women said the shame of becoming homeless had impacted on their mental health. As one woman said, "*the emotional side it just brought me right down to feeling worthless…and there's nothing worse than…feeling like, so far in life and then told that you're worthless."*

Some participants discussed being diagnosed with depression and bi-polar disorder in the past and were now taking prescribed medication for these conditions. Other participants had been admitted to into psychiatric hospital/ institutional care many years previously and spoke of how this experience had left them still feeling traumatized and distressed. Women spoke of the trauma they had experienced in the past and some had developed PTSD as result. One woman spoke of how she has "*the memories and the flashback of the bashings all the time",* with another woman speaking of how she had been suicidal *"I thought what have I got to live for?"*

Many women spoke a lot of how their experience of grief had impacted on their mental health. Several were still mourning the death of their elderly parents who had died after or while the participants were transitioning into homelessness. Women also spoke of the grief they continued to experience at the loss of their marriage/ relationship and the loss of their homes, and three women spoke of their sadness at the loss of their profession. Some women were still grieving for their babies who had died in infancy, many were grieving the loss of their family and their children from whom they had had been or remained estranged. One

woman has only limited contact with her family which she attributed to her acrimonious divorce *"the problems have been ongoing, they're sick of it… and they've got their own problems to deal with."*

As one woman expressed *"The abuse….at the moment, that's the least of my worries. Abuse I can deal with. Physical stuff like that you can deal with. It's the mental/emotional side of it that I find hard to deal with…. Bruises heal. The mental stuff doesn't."*

Several women were ongoing grief counselling and others reported they had found regular counselling with a psychologist helpful in providing them with the support they needed going forward with one woman say *"if you find that some things are straining your life, and it brings you down emotionally, you've got to move on to the next step."*

One woman used the metaphor of showering to help her as an emotional strategy to "*wash off the day"* because she personally had found it helpful and felt providing showers for other homeless women would also give them a sense of control, as well as feeling clean.

6.2.4.2 SHSP perspectives

All the SHSP providers considered mental illness to be a major health need which may be related to their lifetime experience of chronic trauma and/ or family violence. One provider observed that particularly for ATSI women *"grief and loss are massive…. they have loss, don't get any support with that, then they have (more) loss and then it just snowballs throughout their life."*

Providers spoke of how women experience stress and depression because of their homelessness experience, of loneliness, social isolation and *"an incredible amount of grief around the loss of their former life"*, leading to depression and associated mental health issues. A case worker at the older women's hostel highlighted the key mental health issues for many women saying *"most of our ladies, suffer from anxiety and depression…. and because of that, they often experience tiredness, exhaustion, fatigue and a lot of them emotional stress… most of the residents have some mental illness, and some with schizophrenia."*

Another staff member working with the women in the transitional accommodation hostel spoke of how distressed the women are when they first arrive, of how the women are in a state of shock and disbelief at what they have been through and now were homeless. She said she had found *"depression and anxiety is major in almost everyone… homelessness is very traumatising and very humiliating as well, and so there's a lot of shame and guilt, there's a lot of anger involved ... sometimes they're in a sort of disbelief as well… in a state of shock and disbelief and abandonment…sort of feeling… where are my friends and families that I showered all my attention…and now where are they?"*

A case worker at a domestic violence refuge recognised the health needs of women coming to the refuge comprised *"mainly mental health needs",* presenting at the refuge with mental health concerns and illness including bipolar and post-traumatic stress disorders. The refuge refers these women to a local GP who can refer them on to a psychiatrist and/ or a counsellor as appropriate.

The providers generally felt that mental health services were unable to adequately address the needs of their clients and reporting difficulties supporting older homeless women getting to access mental health services including time delays and long wait lists. An inner-city case worker said she had found… *"Mental health is so under-serviced, it's just unbelievable … same with drug and alcohol. The two causes of homelessness, the two major causes, this is my opinion ... I think there is about a three to four month wait list for drug and alcohol support, detox and rehab."*

As one case worker stated with regard to seeking mental health support for women escaping domestic violence... *"when it comes to mental health and drugs, there's a waiting list... so you ring up and you talk to them and they say, 'can I talk to the client and you pass the phone over, talks to the clients "oh yes, we can make you an appointment" ' …in 2048!''* A SHSP manager estimated that probably about half of these women awaiting appointments leave the refuge and return home to the abuser.

6.2.4.3 Healthcare providers' perspectives

Healthcare providers also spoke of the significant impact of mental health needs including depression, stress and trauma that they had found in women experiencing homelessness. A psychologist observed that almost all the women seeking counselling after becoming homeless post domestic violence present with chronic insomnia.

A nurse described how the women initially present to healthcare services as quite physically and mentally unwell. While they have been coping at some level from day to day, they have not sought help for their underlying mental health issues "*We're seeing women in transitional accommodation where you have more of the unravelling of long-term things, starting to come to the surface because it's been pushed down for so long, because they're just doing the survival flight or fight thing day after day, after day, after day….then once that drops away then you see all the mental health stuff come up to the surface…we find that depression can creep in and then we find that the trauma that has been suppressed for so long and comes to the surface which can be overwhelming for people."*

Others reported that they had seen what they considered to be the situational crisis experienced by women experiencing homelessness. *"Generally, the things I see with this population group coming to me are requiring treatment for anxiety and insomnia…generally related to their situational crisis…generally anxiety or depression, or a combination of both, or they have some underlying generally not properly diagnosed post-traumatic stress disorder"* (nurse). *"What people in the psychiatric profession would call an adjustment disorder. If you become homeless, that's a whole new identity these women have… an adjustment disorder … a major change in their lifestyle and having real difficulties coping with it"* (psychologist).

Healthcare providers noted that alcohol is used by many of the women as a coping mechanism '*'there's not so much of a problem with illicit drugs, but alcohol is a problem … quite often you never find out whether their alcohol dependence was an issue before or after their situational crisis"* (nurse). Similarly, while drug and alcohol use was common in homeless women presenting to ED, a medical practitioner described how these women often use methamphetamine in order to

stay awake during the night when it's most dangerous, rather than using it to make them feel good. The women use sedation and tranquilising medications to help them sleep at night and also *"to numb their anxiety, their despair, their depression … because being on the streets is often related to both mental health and drug and alcohol."*

Healthcare providers also noted inadequacies in services with one medical practitioner saying that he felt two major gaps in service delivery were *"Mental health, definitely. Drug and alcohol".* Others commented that when homeless people move around the metropolitan area, if they get attached to one mental health service, as soon as they go to into another (suburban) area, they need to find another mental health service, so these people fall out of the system and become lost to mental health service provision.

There is a lack of follow up for people being discharged from hospital mental health services as... *"most of the time people are just sent out of hospital, into the void"* (medical practitioner). However, the nurses working with the HHC team had noticed that since they have been working with the Royal Perth Hospital Homeless Team (RPH HT), communication has improved with Mental Health Services in the inner city. One nurse suggested this may be attributable to some of the ED doctors who also work in RPH Psychiatry who are aware of HHC and the RPH HT.

6.2.5 The complex interaction of physical and mental health needs

As reported by the healthcare providers, in addition to mental health needs, many older homeless women also suffer from a range of complex physical and mental health issues that may pre-date their homelessness but nonetheless have become more complex as a result of it. Most women were experiencing mental and physical fatigue, exhaustion and insomnia and required a range of prescribed medications in order to manage these health conditions. Providers had found it difficult to separate the women's multiple overlapping physical and mental health needs which had become exacerbated by the stress of homelessness. Chronic diseases including muscular-skeletal problems and diabetes were frequently cited by healthcare providers as a common health issues experienced by older homeless women. Women's circumstances leading

them to becoming homeless and where they were living impacted significantly on their mental and physical health. Whilst women were aware of the need for preventive health, this was not a priority for them as they were still trying to adjust physically and psychologically to their experience of becoming homeless, and this was supported by the providers.

6.2.5.1 Perspectives of the women participants

Several women participants felt they still had virtually the same health issues as they were before they experienced homelessness except that the combination of getting older and not having a stable place in which to live had impacted on their pre-existing health conditions made their health worse. Several of the women living in the transitional older women's hostel said that they now felt safer and their receiving assistance from the staff to seek more permanent accommodation had made them feel better in terms of their health.

Women spoke of the many contributing factors that they considered had resulted in their becoming homeless and how these affected their health. Those women who had left violent relationships mostly reflected that their health was now better even though they were homeless than when they were in that relationship. Most of the women participants reported that they had significant mental health concerns and multiple physical health problems including diabetes, joint and back pain, insomnia, anxiety, depression, emphysema. As one woman put it, her main health needs were *"asthma, antidepressants and arthritis".* Another stated that her health needs of Lupus, diabetes and high blood pressure may be attributed to her experiencing stress at the loss of her job and the subsequent breakdown of her relationship. "*I can't believe what I've been through*", she said.

Other health problems described by the women included blood pressure regulation, emphysema, asthma, heart disease, middle ear problems, tendonitis, diabetes, recurrent skin infections and spinal problems due to osteoarthritis or old injuries as a result of violence from their partners. There were some instances where participants had been severely beaten by their partners/ husbands to the extent that resulted in a head injury or an Acquired Brain Injury (ABI) and these women were experiencing headaches and, in some instances, episodes of

memory loss. One participant had lost an eye when she was punched in the face by her husband. Several participants who had sustained injuries from falls were still experiencing ongoing pain and limited mobility, and others experienced pain in their feet, bunions, ankles and knees which also restricted their mobility.

Being healthy simply meant to one woman *"no pain"* or *"not having a lot of pain".* One woman explained *"I am on medication, quite a lot of it… and that's helping with the pain I have. Well, most of the pain…. mainly due to fibromyalgia, and the rheumatoid arthritis…. I think it's through the rheumatoid arthritis that my spine is deteriorating… especially in my lower back."*

Most of the women were on numerous prescribed medications including sedatives, steroids, nerve pain killers, anti-psychotic medication. As one woman said *"I often have up to five or six scripts at a time to get pills. Because I'm not only on the diabetes medications, Metformin and Gliclazide…there's two diabetes medications, plus I'm on Nurofen for my back. Plus, I'm on Endep to try and help me sleep. And I've been on antibiotics on and off for the last few months because of the emphysema, plus steroids"*. Others said they also purchased additional over the counter non-doctor prescribed medications such as Paracetamol, vitamins and minerals (e.g. magnesium for leg muscle cramps).

Many of the women said their main health need was to be able to sleep, having been exhausted from the experience of being homeless and then relieved to get a roof over their head. Virtually all the participants in transitional accommodation said they required some form of medication to assist their sleep such as Temazepam and Serepax *"when I don't have the tablets I dream, and I don't like my dreams."*

One woman spoke of how difficult it was for her to manage menopausal symptoms while she was living on the streets, although the women's predominate need was about their need for female-provided counselling.

Participants all said they aware that being healthy meant having a good lifestyle and that this included exercise, diet, managing stress, limiting alcohol and smoking. However, many of them were living chaotically and many still smoked and drank excessively. One woman sadly shared her experience and

insight *"well my health, well, it's gone …because I'm not doing the right thing by my tablets… I need to take my tablets three times a day, but because I'm on the streets, and haven't got my tablets, so I don't take 'em, so I just end up drinking …and I probably get sick every day."*

Some of the participants smoked cigarettes and were trying to cut down and/or give up. One woman told of how she spends approximately $180 for fortnight for anti-smoking medication and suggested it would help if this was funded.

Many of the participants were aware of the health benefits of exercise and one woman suggested that one thing she had seen with a woman was being able to be in a heated pool*…" like they have at St Johns ... and being able to do weightless exercise. There are a lot of people who are on frames … the kind of hydrotherapy could be good for."*

6.2.5.2 SHSP perspectives

SHSP participants reported that the women under their care presented with a complexity of healthcare needs, requiring support in terms of managing their mental and physical health needs "*They can be very acute it's a downhill trajectory in terms of physical and mental health."* (SHSP manager). Another said *"I've seen a variety of needs, a lot of chronic health, diabetes, unchecked or unmonitored, general chronic health conditions, a whole variety of them…mental health is a huge one. For those women that we are seeing that are homeless that are elderly or getting elderly… you can see their health needs are more acute"* (SHSP manager).

There was a general view that women who were more recently homeless and for a shorter duration experienced better health than those homeless for a longer term and were *"chronically homeless"* (and may have been homeless several times). However, there were a range of other inter-related factors involved. All of the providers suggested that a complexity of issues including financial and housing insecurity had impacted on the women resulting in their becoming homeless and subsequently impacting on their mental and physical health. *"It's financial, it's emotional, and it's physical".* All SHSP stressed that the issues

relating to women experiencing homelessness and their health needs were complex and inter-woven.

"It's very, very difficult to talk about anything in isolation… usually if it's someone that's just lost their accommodation and because of whatever x, y and z factor, they're easier to rectify that, to find them accommodation, to get them housed. Not always, but getting them housed and keeping them housed is huge." (SHSP manager). Another SHSP manager reported *"there's a complexity of health care…. a lot of the women have long term psychiatric, psychological stresses that if you're long term in the (homeless) community that gets really reinforced …there are a lot of agendas there."*

Service providers noted that older women suffered with osteoarthritis, especially with the knees, chronic injury, arthritis, painful knees and hips, hypertension, cancer, heart disease and heart disease linked to diabetes. The manager at one facility was aware of older homeless regional women (both ATSI and non ATSI women) coming to the city for cancer treatment… *"We've had women homeless because of cancer… they're coming from the country (regional areas) … for long stints of treatment."*

Incontinence (mainly bladder but occasionally bowel) was another issue. A case worker observed that Hepatitis C was common in women (all age ranges) at an inner-city centre.

SHSP in all the settings noted that most of the older women struggled with maintaining their prescribed medication for multiple health conditions including mental illness. This is due to several factors including high levels of anxiety, remembering to take the medication and keeping their medications secure. For women living in the transitional hostel a worker commented *"when you think of all those healthcare needs, especially if there's medication involved, there's that need for them to be prompted at times, because of that tiredness and anxiety that they experience… they can't kind of put their lives in order to even remember to take a pill …or, when they're running out, go in and get a prescription."* Staff working with women on the streets spoke of the problem the women have keeping their medications safe from other people, and with women with diabetes and mental health problems who constantly have their medications stolen.

Case workers had noticed that some of the women were experiencing gynaecological problems which was a *"huge"* problem for these women, especially if they were living on the streets. Other SHSP said they had seen that menopausal and peri-menopausal problems were impacting on the mental health and their general well-being of some of the older women utilising their services. One manager noted the increased risk of STDs for homeless women who turn to prostitution as a means of survival.

Providers commented that maintaining a healthy weight was an important health issue… *"we have quite a few ladies here who are overweight, obese, but they don't have diabetes "* (caseworker at a hostel). Another case worker at a drop-in centre, said she had observed that although there's plenty of food for people on the streets *"it's mainly stodge, it's cheap processed food."*

Many of the women who were residing in the centres and using the drop-in centre smoke cigarettes. Case workers suggested that a lot of these women had been long term smokers who have never considered giving up and that often this impacted on their finances with a decision being made between buying cigarettes and buying food. *"That's all they've got in life…that's their only pleasure…they have no money, especially if they smoke… people will go without food to buy their cigarettes."*

SHSP interviewees reported they had found that women experiencing homelessness frequently over self-medicate with alcohol combined with their prescribed pain and anti-psychotic medication to cope with their anxiety and depression.

As one SHSP manager said *"preventive health care…all that stuff we take for granted… like mammograms and Pap smears"* were not accessed by homeless women in the inner city. *"it sometimes can be so complicated so it's easier not to bother… then they just rock up to ED whenever there's an emergency rather than any sort of preventive measures."*

6.2.5.3 Healthcare providers' perspectives

Healthcare providers discussed how as women become homeless and move from place to place, and the impact this has on their health. They generally agreed

with feedback from SHSP that recency and duration of the time a woman has been homeless definitely has an impact on her health. They had found that those women most recently homeless tend to be physically healthier than those who had been homeless over a longer period of time. Basically, they agreed that the longer a woman is homeless, the worse her health. However, they also agreed with SHSP that the women's health also depends on other variables, including the contributing factors to the woman becoming homeless in the first place and her living circumstances. The problems of distance and isolation in WA can contribute to older women's homelessness in this State. For example, *"if you are from a rural region and you come to Perth because it's the only place that you can get the treatment that you require ... if you don't have the finances to support yourself, you are often discharged to the street from a hospital, it happens. Perth is the most isolated city in the world, rural isolation is very important, it doesn't matter what group you're from, whether Aboriginal or not"* (nurse).

A medical practitioner identified that probably the most important health needs of women rough sleepers presenting to ED are around mental health but that often their first need is to just rest as they are exhausted from the trauma of living on the streets "*they may still feel a need to just numb themselves from things like sexual assault, separation from loved ones… particularly children… and it takes them a while to process that."*

Healthcare providers also reported a range of physical health needs in the women including physical exhaustion and fatigue, diabetes, injuries from falls, liver disease, bladder incontinence, skin disorders and lung disease. The predominant health need of older homeless women presenting to RPH ED was that they were *"exhausted, extremely run down and haven't had any kind of comprehensive healthcare for a long time"* (nurse).

Diabetes was frequently cited by healthcare providers as a common health issue experienced by older homeless women. One nurse spoke of a woman under her care who had recently had part of her foot amputated due to poorly managed diabetes in the past. A medical practitioner and nurse both reported they have noticed that diabetes and associated peripheral vascular disease is common in Aboriginal women.

Falls were a problem for older women due to medications and/or alcohol and that they had had also noticed cases of Hepatitis C where the impact on the liver was compounded by alcohol and drug abuse (medical practitioner and nurse).

All healthcare providers spoke of the difficulties of managing the multiple acute and chronic overlapping health issues (multiple morbidity) experienced by homeless people, including women. Healthcare providers said they had seen a higher rate of morbidity in this population than in the housed population. They had found that the health of homeless people with chronic illness was further compromised by inter-related factors including their health not being a priority for them, and/or their being depressed to deal with their health problems, exacerbated by their not seeking healthcare until they're *"really sick and presenting late to the acute health system…the longer you are homeless, the more problems you have and the reason for that is more time when you can't deal with your health problems and more when you can be traumatised"* (medical practitioner).

Providers spoke of how women can become homeless if they have chronic illness that is poorly managed, and the family is unable to support them, or they're dislocated from their family in some way. They also had seen situations where a family breaks down because the health issue is too severe and too confronting, or where a single woman had become homeless as a result of a health issue that caused her to lose her job and then become homeless because she couldn't pay the rent.

Women experiencing homelessness may have dual or three diagnoses and thus a combination of physical health, mental health, drug and alcohol problems…"*Basically everyone, women included, have the same medical and mental health, drug and alcohol, problems as the mainstream population, but they occur two to six times more commonly."…"it's quantity of complex multi-morbidity, is what homeless health is all about … then you add into that the traumatic experiences and it gets really tricky to manage…all of them come together."* (medical practitioner). A nurse explained *"when we initially meet people, they're presenting as quite physically unwell. Often quite mentally unwell. Sometimes they have drug and alcohol problems and very often*

trauma… some kind of trauma that has either happened since being homeless or has led to them being homeless or both."

All doctors and nurses interviewed commented on the high prevalence of sexual assault for women living on the streets, and the associated sexually transmitted disease. An ED doctor observed that the women will only presented with gynaecological problems, for example, menorrhagia, *"because she's' bleeding and can no longer manage on the streets …she will come for that but apart from the things which really impose on her ability to survive, they're not really interested in that."* A nurse spoke of how they occasionally have women who present with a malignant breast lump the women had ignored due to fear but mainly because it was *"not their immediate need."* Similarly, a medical practitioner spoke of how women who are in survival mode *"pushed their preventive reproductive health into the background"*. Another medical practitioner noted that women clients have very low Pap smear rates and that *"screening and preventative healthcare are non-existent"* in the lives of homeless women.

A healthcare adviser stated that *"the research is beginning to show that people who are homeless, or on very limited incomes, just to pay the rent …the money they might have spent on medicines and food is last in the list. If they become homeless through being unable to pay rent, these conditions that these women may already have, prior to their being homeless, are made worse by the fact that they can't afford medications and a nutritious diet."*

Healthcare providers noticed the difficulty of compliance with medication experienced by women in chaos and who sleep rough, many of whom lose their medication, or have it stolen. One nurse spoke of some women who visited the clinic *"I think they think ...'well what's the point of me going to get my diabetes medication, because it's going to get pinched, or I'm going to lose it, so I might as well not bother'",* and said this exacerbates their health conditions, because they're not talking the medications they need. Some of the providers carry a stock of urgent medications which is funded by donations but also that once women have found some accommodation, many of them need assistance to *"get their medications right."*

6.2.6 Stigma, shame, embarrassment and fear of being judged

All the women interviewees reported a high level of shame and fear of stigma that prevented them from seeking healthcare where they may need to disclose their living situation or admit they have a mental health condition. Many were reluctant to tell healthcare providers they were homeless for fear of being judged and spoke of how hard it was to ask for help because that meant that they had to admit their problems. Some had found it more embarrassing to admit they had a mental illness than to admit they were homeless. Providers agreed that women experience significant shame and embarrassment about being homeless, which, in turn, impacts on their health and their capacity to seek help.

6.2.6.1 Perspectives of the women participants

Participant women spoke constantly of their shame and embarrassment and the stigmatization they felt around reaching out for help from healthcare providers and their personal feeling of embarrassment had stopped many of them seeking and accessing the healthcare they needed.

In the words of one woman *"When I became homeless, I was too embarrassed to go and see my GP because he's known me all my life and I felt like… I'm going to have to admit I actually am a failure at the moment in my life."* Another woman had found it hard as an older homeless woman to ask for healthcare *"because a lot of people that you ask, they look at you as if to say, "are you nuts?"* Women were also very embarrassed about their dependence on alcohol and other drugs and afraid to go to health services because *"you don't want them to know your addictions."* A woman who had used the same GP for 35 years, stopped seeing him when she became homeless as she was too embarrassed to tell him that she was addicted to an over the counter medication.

Participants reflected that being homeless definitely holds stigma. *"people make a judgment about you …just for being homeless without any other issue".* Another woman confided *"it's really hard when you hit rock bottom… you feel worthless, you feel ashamed… and you know, people know you, from ages ago and they see you're homeless. There is a big stigma and embarrassment about being homeless."*

The women also reported that staff understanding, attitudes and communication were both barriers and enablers to their health care. Women said how important it was for them that staff had compassion, empathy and good listening skills. Many of the women were most concerned and felt very sensitive about being adversely judged by clinicians and healthcare staff and spoke about how this often prevented them from seeking healthcare. Where they perceived they had been adversely judged, this prevented them from returning for continuing care. One woman refused outright to seek medical care after being treated disrespectfully "*I won't go to them – that's it!"*

This viewpoint was very strongly echoed by an ATSI woman who stated, "*it's how you approach people, it's how you speak to people".* She said that for many ATSI women, *"because of what happened with the Stolen Generation they don't trust …because authority's always around them so the last thing on earth they need is someone that's reaching out to help them to be authoritative……don't be so authoritarian, walk a day in their shoes."*

Others spoke of their different experience with healthcare providers with one saying she found staff in the mobile street doctor service *"tend to have a different attitude towards women… because they know we're in a situation where often we are abused, or raped, or whatever, because we're homeless …they tend to be a lot more compassionate. More so that your family GP…in my experience anyway..."* while another said of a large suburban GP practice she had visited was *"very government bureaucracy bound, stringent in their administration of how they deal with you, it's very clinical and it's not very comforting …sometimes on the other end doubt your sanity because of it ….and yet you know it's not your fault."*

Several women had utilised hospital EDs as their predominant health service and feedback on their experiences was varied. Some reported they had never experienced any problems in ED with staff being *"kind and gentle"*, and empathetic, whilst others had profoundly negative experiences. For example, a woman who had been homeless for several years spoke of how embarrassed she was to present at Royal Perth and while in an ED cubicle, overheard the nurses' comments *"well, she's only coming here for a bed for the night… and I thought hang on a minute, I've actually been sick. I've had a head injury. I've come in for*

a reason." Another woman said she had found *"Charlie Gairdner's is a fantastic hospital compared to Royal Perth, the level of care is a lot better, the staff are nicer".* A different woman said the only service she uses is the RPH outpatients' clinic where *"the staff are the loveliest people",* but at the same time she had been *"treated like disgust"* by the security staff.

A Fremantle woman who was sleeping rough spoke of her experience of health providers over the years she has been homeless *"because I'm an ex-heroin user for a start they usually think I'm in there after drugs, and I've been on a lot of drugs in my life like S8's, so that goes against me …. I get the jitters when I go to the doctors, except for the Street Doctor, because they're dealing with people like me constantly, whereas your normal GP… because I know the reception I'm going to get, and know when I'm going to ask for it they're going to question, even though I've been on these drugs 30 years I still get the third degree as to what I'm asking for, why I want it."* She receives a similar reception when she goes to the chemist "*I'm too embarrassed to go to the chemist and say look my bag's been stolen last night, all my medication's gone. I really need these … they often won't do it … they think you're lying straight out. It doesn't matter if you're genuine or not."* She went on to say how St Pats are her first really good experience with health providers, commenting that when she went to the mental health services respite clinic (over 10 years ago) they would doubt her, question her, *"keep me safe for a couple of weeks, then I'm back out on the street."* All of the participants interviewed in Fremantle praised the Freo Street Doctor service and their non-judgmental staff *"they understand that if you're living on the streets shit does happen."*

One woman's experiences of RPH ED were quite negative. Nonetheless, she spoke of the last time she was at Royal Perth ED *"I was actually pleased to see they've got a big banner up there regarding the care of the homeless now….and they've got the doctor there now. I think it's absolutely fantastic! It's about time that they've got something in the hospital to say the homeless will be cared for 'We will take notice …and care for you, even if you are homeless'. I was so pleased… because Royal Perth has got a bad reputation with the homeless who say …'don't go there. If you get an ambulance, ask the ambulance to take you to Charlies'…Gairdner's not Royal Perth.' "*

In terms of access to primary healthcare services, participant women with a range of health conditions spoke of their need for ongoing follow-up appointments with the GPs who now managed now their care. Whilst they strongly believed that accessing GPs was one of their major health needs, their main problem had been having to find a new doctor all over again and recount their history, which they found distressing. Women who had fled their homes to escape domestic violence said they had found it difficult to find a new GP in whom they could confide. At the same time a woman who was badly beaten by her partner in a domestic violence incident said her female GP in a Wheatbelt town and her GP in Perth were both "*awesome*" and know "*exactly what I've gone through*". Overall, women spoke positively about their GPs…*"I've had some very good doctors"*, and most participants said they had experienced *"good health services."*

6.2.6.2 SHSP perspectives

SHSP said they had found that women's fear and distrust of the health system, including healthcare providers, were significant barriers to their accessing health services …*"trust, confidence, the shame factor, fear"* as one provider stated. Providers suggested that women were reluctant to disclose their health needs, particularly around mental health… *"the big barrier, untreated mental health…it's actually about protection and non-disclosure so as a service provider… in this space, the biggest barrier for us is around non-disclosure."*

The barrier of non-disclosure was demonstrated by a manager who told of how a woman utilising their homelessness service had died. At this her funeral, the staff learned of this woman's life story, that she had been a registered nurse, dedicated to her profession and had done amazing work but she had been forced to sell her home because of mental illness including psychosis and squalor. She eventually ended up in the homeless centre, but never disclosed her diagnosed mental illness *"for many people it's about protecting themselves", because at some point they've gone through the institution of mental health, hospitals…the result of that is non-disclosure."*

Another SHSP manager mentioned that she had observed that a lot of older women are *"quite private about their situation and they're not going to share it very easily unless they've been in the homeless situation for a very long time, in which*

case they become quite open about their situation because …they've become used to it… it's normality for them. But a lot of older women, new to homelessness feel a bit of embarrassment, they're very vulnerable…they're afraid."

Receiving assistance from homelessness service providers to re-establish their personal identification documentation required for social security application had been an important first step in the process for several of the women interviewees. The following quote demonstrates how SHSP staff assist women in this process. *"They don't have an address. So, it's been three weeks and she's not on the pension, she has no money, here bank's zero, so where does she go, someone like that?".* This common situation was further elaborated by a healthcare adviser who reiterated many older women present with malnutrition and other age-related chronic diseases because they have spent most of their money on rent and had limited funds for medicines and healthy food.

"The barrier is the attitude of the staff and the response". An example was provided of a woman who had been abused by her partner in the past, went to a mental health service where she was put off by the attitude and response of the staff and now is quite reluctant to go there again as *"here is another abuser… you know...attack her again".* This provider spoke about how these women react to staff and *"shrink back into survival again, and they're not hearing anything anymore… they're quite fragile really…. it's sometimes quite reactive to how you treat them…. you have to build their trust."* At the domestic violence refuge, staff receive ongoing mental health and psychological training as well as ongoing sexual assault training because many of the women had been sexually abused, *"if not by their fathers, uncles, best friends… and that all leads to mental health issues."*

Providers also cited examples of where staff were sympathetic and compassionate towards people experiencing homelessness rather than treating them as *"a second-class citizen",* despite one particular client who was incontinent and *"stank to high heaven."* Providers spoke of how important it was for health providers to understand the impact of trauma on people (including women) experiencing homelessness and that being homeless was *"the other layer of being stigmatised".* One provider felt that an individual approach might be needed to a GP to request bulk billing services, and enable a heightened

awareness with their nursing staff, whilst some *"might not be that receptive at all."* An inner-city case worker spoke of how the Homeless HealthCare team works towards eliminating stigmatisation and treating each individual with respect.

Providers suggested that many healthcare providers are unable to cope with the complexity of the needs of homeless people and that, often, homeless people are told… *"fill in this form' or come back at 2 o'clock, you can see such and such a doctor… that's what they're used to when a homeless person comes in, that's what they get and they get frustrated".* Another provider proposed that healthcare staff need to *"humanise the person, to see them as somebody's mum, somebody's grandmother … there's a real suggestion that they've lived ... they live… unproductive lives and many of these people have contributed enormously to society and paid their taxes."*

A SHSP manager stressed the importance of creating a non-threatening and perceived safe environment. She reflected on two older women they had been able to help and assist and that it took months of relationship building with them before *"we identified the terrible abusive situations that were happening with them, where younger people were coming in and raping them, and using their place and dominating them, and they're so needy that they're accepting it, like it was their fault, and it was a true victim situation. It was terrible. But so much pride and so much fear and embarrassment that they didn't come out with it… so it took a long time to uncover that was happening. And both those ladies well into their seventies."*

SHSP had noticed that the waiting times in emergency has a *"huge impact"* on some women, especially if they are experiencing mental health issues, for example *"if they're hearing voices, and trying to manage in that sort of environment" so they "leg it, and don't get the assistance they need."*

One of the SHSP managers suggested the value of greater GP identification of women's vulnerability and then providing that information into services or supports. She suggested the possibility of having mobile outreach teams that can connect with women before they actually find themselves on the streets*, "before the damage is actually done as then they become very vulnerable. It's a very,*

very difficult complex situation which is why we need to try and look at wherever possible, early identification and intervention."

6.2.6.3 Healthcare providers' perspectives

Healthcare providers agreed that women's shame and the stigma of homelessness prevents them from seeking health care, that women hide the fact that they are homeless, they're dreading someone asking them about their living situation because they'll have to explain, and that women are especially ashamed to admit they have a mental health condition.

The psychologist spoke of women whom she had counselled who had developed depression as a reaction to their becoming homeless resulting from domestic violence. *"If women go anywhere and say, 'I'm on an anti-depressant' say, they'll get a reaction from other health professionals. Sometimes they're dismissed, their other concerns aren't taken seriously. There is a lot of stigma around mental health … in the medical profession in particular towards anyone who says, 'I'm on anti-depressants,' or, 'I'm on this medication, I can't work.'"*

Providers all agreed that that there is a common barrier in that women fear being judged, particularly for their being homeless. One medical practitioner spoke of how women have a lot of shame about being homeless, and how a woman might not go to her normal GP because she doesn't want to admit she's homeless and let other people see her in that circumstance, to have to ask for bulk billing because she can't afford any sort of private billing and admit she can't afford to purchase medications because she doesn't have the money any more. Another medical practitioner said *"they're ashamed … scared of so many different things so overall it means their health needs are not being met adequately … but it's such a complicated web …I'd say the biggest barrier is them actually coming... presenting, isn't it? The feeling like they're too ashamed."* She spoke of how the outreach workers on the street doctor services help clients overcome some of their reluctance and embarrassment by encouraging them to attend the mobile street doctor van.

Two medical practitioners suggested that many of their colleagues may feel inadequate as they lack sufficient knowledge of how to help people experiencing

homelessness and that their own personal expectations as a health provider they should. Providers spoke of how sometimes staff don't realise they have bad attitudes, commenting *"they often don't realise that their attitude creates some of the problems. So, you see some of the nurses interacting with the patients, and everything seems to run smoothly. When you see others, and they seem to be arguing with the patients. It's not the patients that are different, it's the nurse…it's very much how you approach homeless people"* (medical practitioner).

A nurse said... *"people who become homeless at this age group don't often have the ability to be able to express what it is that their problem is…my understanding of this is that they feel that because they can't tell you what their problem is, you're just going to think that they're a drop kick. And so, they avoid any contact with anyone…they don't put themselves in that position."* She also mentioned how homeless people tell her how they get constantly moved on from GP practices, not necessarily because doctor refuses to see them but they don't even make it into the GP consulting rooms, they're just told to leave. *"They're told to leave. We get time after time, after time, after time, people coming in saying, 'I tried to access the bulk billing. I tried to access this. I tried to access that.' Asked to leave or maybe their behaviour, they got frustrated, because people didn't communicate, tell them to wait, or for whatever reason."* She spoke of how people experiencing homelessness feel judged and prefer to go to places where the staff are less judgemental, remarking *"it's about trust and integrity... that is so important, and that's why that's relationship forming, you don't promise anything that you cannot deliver."*

Another nurse said that people will come into the drop in centres when they're quite unwell, and when they're in crisis…"*people don't come to the drop-in centres when they're travelling okay*." People experiencing homelessness are "*frequent flyers*" at ED, and other services, such as the mobile street doctor service. "*Late presentations to the acute system is the norm. Ideally people with chronic conditions are best managed in primary care and for people experiencing homelessness those chronic issues never get dealt with properly, so the acute system does a great job of maintaining people in their illness … the tendency of them is to wait until they're really, really sick and someone else calls the ambulance… and they end up in the hospital system* " (medical practitioner).

One medical practitioner mentioned the physical barrier of the window in ED (protecting the staff) whereby people must go and talk through the glass to try and get someone to hear them. For an older woman who may have a urinary tract infection or an embarrassing condition, it is extremely confronting and humiliating to have to call out her symptoms to the nurse behind the window, in front of a waiting room full of people "*Some acute care homeless patients are still being discharged onto the street, maybe not intentionally – but people don't ask, necessarily, depending on what's wrong with them*."

Medical practitioners all spoke of the difficulties for hospitals because their outpatients' services are inflexible, and how hospital staff can lack understanding of how to communicate with homeless people. A medical practitioner working with the RPH HT said the way RPH was overcoming the problem of communication with homeless people was to utilise a caseworker taking them to the clinic, or staff from HHC and a drop-in clinic reminding them that "*This morning is when you're supposed to be up to the hospital for your clinic appointment*" or having HHC taking over a lot of the post-discharge care…"*because it's easier to get somebody to a drop-in centre every day than it is to get them to come to the hospital outpatients' department*."

She also spoke of how useful it is for RPH to be working collaboratively with HHC who run drop-in clinics throughout the city and have a good knowledge of many of the homeless population. This means that the HHC team can remind people about their hospital clinic appointments. They can also manage much of the post-discharge care as it's easier to get somebody to a drop-in centre every day than it is, for example, to get them to the plastics dressing clinic.

6.2.7 Financial security

Many women had become homeless subsequent to the breakdown of their relationship. Several of them had been evicted having been unable to pay their rent and transitioned into homelessness including couch surfing, sleeping in cars and sleeping rough on the streets. Women's ongoing financial distress impacted and continued to impact their mental and physical health. They were initially unaware of how to access financial support including social security support. Women living on the streets spoke of how they had their ID and cards stolen.

Providers stressed that older women's homelessness was directly linked to the women's poverty.

6.2.7.1 Perspectives of the women participants

Many women said that their not having enough money to live on had contributed to their homelessness, and how the worry and anxiety about how they were going to pay for food, rent and utility bills (and costs of running in a car for those women sleeping in their cars, including accumulating parking fines) had impacted on their health, particularly their mental health.

Overwhelmingly participants experiencing homelessness struggled financially. Some had become homeless because of financial abuse and had undergone or were undergoing court proceedings. Others who had become estranged from their partners, were left with debts and housing costs such as mortgages and accumulated utility bills. *"During my second divorce, my husband left me half a house, like a house with a mortgage. And I tried to manage, but I couldn't…my car blew up, so I had to borrow, and the bank wouldn't let me borrow more money for my car, so I had to sell that house and I bought another one. And I had started to drink a bit heavily, but the government took my kids away"* (woman now living in short term accommodation).

Feeling financially insecure impacted directly on the women participants' health needs and contributed to their anxiety and distress. Several women attributed their depression to their dire financial circumstances. Some of these women said that being unable to pay for their medications. *"There's a lot of money that goes towards medications…and it keeps building up, every time I see my rheumatologist, there's add on, add on…"* (woman diagnosed with Lupus which contributed to her becoming homeless) Another woman spoke of her difficulties in finding a bulk billing GP*…"Even if you tell them you're homeless."*

Applying for Centrelink benefits was a major source of stress for many of the participants as explained by the following woman….." *"S" been a guardian angel, she's helped me right through to where I am today…organised all my healthcare cards. I'd been living on the streets of Northbridge, I didn't even know how to write… I'd become illiterate…I couldn't even write my name I was shaking that much…she's got me all sorted and linked with the medical side of it."*

A woman now residing in the transitional hostel who had never previously needed to apply for social security reflected on one stressful night and how afraid she was "*that one night spent in the car ...that was the day I had to go out and see Centrecare* (sic)*… until I found here…I have no funds until I get Centrelink use …"*

"Your stuff gets pinched ALL the time… I'm constantly replacing medications and clothes and just everything I own …having to replace it all the time, so it ends up costing you more that it would if you were actually paying rent and had somewhere you could keep everything safe" (woman sleeping rough).

Bulk billing was raised as an issue by many women who said they found it hard finding doctors who bulk bill in the city and they were "*extremely limited for choice".* Another woman said she had not found bulk billing doctors, *"even if you tell them you're homeless* One woman who was experiencing homelessness for the first time stated, *"I always had an income, and this would be the first time that I found I just couldn't turn around and get that help."*

The cost of accommodation when women first experience homelessness impacts on their health*…"Well, I would be healthy if it wasn't when my sister embezzled my home unit overlooking the water …I used some of my pension to stay at hostels, so it's $30 a night"* (82-year-old homeless woman who was taken to RPH by backpacker accommodation staff after a dizzy spell).

Participants spoke of how SHSP staff had helped them in a range of ways to access social security and accommodation, thus helping the women overcome their extreme anxiety about their financial insecurity and housing.

6.2.7.2 SHSP Perspectives

Receiving assistance from homelessness service providers to re-establish their personal identification documentation required for social security application had been an important first step in the process for several of the women interviewees. The following quote demonstrates how SHSP staff assist women in this process. *"They don't have an address. So, it's been three weeks and she's not on the pension, she has no money, here bank's zero – so where does she go, someone like that?".* Another comment described the impact of financial insecurity on the women *" they feel hopeless… and it's that hopelessness they*

have to get through… like the lady I just saw said to me "I almost thought of killing myself" … it was in that sense of 'why bother' and I said 'well you've seen through it… your pension's almost there now" (SHSP manager).

For women utilising inner-city drop in and homeless services, one interviewee commented *"it's actually the financial component that really hasn't been highlighted by the individual, but it's there… it's all around the trauma or the assault or whatever the cause but it becomes financial."*

Interviewees reiterated the impact of older women's poverty, *"poverty…the reason they became homeless in the first place … has an impact on their health…women who are poor have more health issues because of their stress… then they become homeless and it increases their stress"* (SHSP manager).

The domestic violence case worker spoke of the huge debts carried by homeless women as they were made responsible for paying utility bills and household expenses over the years while they were being abused *"amazing the debts, tens of thousands."*

6.2.7.3 Healthcare providers perspectives

None of the health providers interviewed could recall any women they had seen who had become homeless because of financial reasons alone. *"Most of the women have a constant stress about how they're managing financially…asking for help can be a bit difficult because they think they should be able to manage."* (psychologist). They had seen women in financial crisis due to relationship breakdown, who had lost their income because the spouse was been the main earner and other women whose spouse had died and suddenly, they lost that income, and there was significant debt. But in terms of reasons for becoming homeless there was *"no simple thing as a simple answer"* (nurse).

The healthcare adviser had seen instances where the death of a spouse had placed older women at risk of homelessness, especially for older women may not be able to afford to continue living in the house as the cost of rates and utilities remain the same, but their pension reduces.

When healthcare staff initially meet women, who are sleeping rough or who have not had stable accommodation for a long time, they're predominately quite unwell. A nurse working with people experiencing homelessness (mostly rough sleepers) had noticed their health problems such as skin conditions became exacerbated, the longer they've been exposed.

Some women feel better off living in their car where they can *"escape the responsibilities of looking after all the grandchildren and dysfunctional children, they're often under such a lot of pressure that they feel better off in their car."* (medical practitioner). She had also commented that living on the streets is very risky for women as they're much more vulnerable, they get sick because they're getting cold, may suffer from exposure and can't look after themselves.

The HHC team have observed that the health of women who are staying in different types of accommodation and moving house all the time, having no permanent fixed address, couch surfing, staying in boarding houses and can't afford it "*…obviously there's taking the elements out of it, so people aren't exposed to the elements all the time if they're still in that 'where am I staying for the next day, week' it's still the primary concern rather than … oh I've never had a Pap smear or my knees are starting to hurt."*

Healthcare providers said they were often unaware of couch surfers… *"It's such an invisible population… but I'm sure they exist".* A case worker at an inner city homeless and mental health centre said many of the women visiting the centre couch surfed and she had found the couch surfers were marginally in better physical health than rough sleepers but *"obviously, that's still a bad situation…they've still got the anxiety and stuff."*

"Because they've had a relationship breakdown…and they've lost their income, because their spouse has been the main income earner, or their spouse has died...and suddenly they've lost that income" (nurse).

6.2.8 Cost of healthcare services and pharmaceuticals

With little financial resources and complex comorbidities that often required access to medical and allied health services and pharmaceuticals, the cost of healthcare was difficult for most of the women, particularly where they had been

prescribed numerous medications. This situation was exacerbated by loss of Medicare and other personal identification cards, theft of drugs and the cost of transport. Access to non-Medicare funded healthcare including dental services, Allied health and psychological support services was difficult for many and unaffordable for most.

6.2.8.1 Perspectives of the women participants

All the women spoke of their need to find affordable GPs, medical specialists, allied health providers and dentists. They also spoke of being able to access affordable medications was a major health need for them, particularly where they had been prescribed numerous medications.

Cost was a consideration and a barrier which limited some many participants' access to healthcare with the lack of availability of GPs and medical specialists that bulk billed raised as an issue by many of them. When women were asked if there was anything that stopped them getting the health services the response was mostly *"Yes. The cost. The cost".* Bulk billing was raised as an issue by many women who said they found it hard finding doctors who bulk bill in the city and they were "*extremely limited for choice".* Another woman said she had not found bulk billing doctors, *"even if you tell them you're homeless".* Nonetheless, some women said they had found out where to go and only went to those places that were Medicare funded and /or were free of charge. The cost of transport was an issue for women needing to access GPs and specialists beyond the inner city.

The cost of medications was also an issue for the women, especially if they had been prescribed numerous medications. Women had found that this consumes a considerable proportion of their pension money and compromises their ability to meet their other basic needs. A woman with ongoing mental and physical health problems said she spent $60 a fortnight on her medication even though she was eligible for Healthcare and Pensioner Concession benefits. For Aboriginal women, having access to "*Closing the Gap"* funding was beneficial as they were able to access to free medications. Several of the women were diagnosed diabetics who had found it particularly difficult to manage their condition if they were sleeping rough because of their inability to sustain a healthy diet and continually having their medication stolen.

Those participants who required medical specialist consultations spoke of how they are required to pay a Medicare gap fee if they go outside of the public health sector. One woman said that her specialist charges a reduced fee, but she is still required to pay to cover the gap. Because she is disabled, she must catch a taxi to visit her specialist *"and it just keeps building up…every time I go to my rheumatologist, there's an add on but he's been kind enough to lower the bill …so I end up paying about $45".*

Virtually all participants said how difficult it was to access find a dentist they could afford and expressed the need for dental care. Some thought their dental problems might have been compounded by their other health issues, including one woman requiring major dental work for which she told by the dentist was due the large dose of antidepressants that she had been taking over several years.

Some participants' spoke overwhelmingly of how helpful, supportive and kind they found pharmacists and pharmacy staff, particularly in the city and East Perth. These pharmacies dispense their prescriptions and several of the participants relied upon them to know what tablets they're on, even if they lost their prescriptions, tablets or had them stolen.

6.2.8.2 SHSP perspectives

Providers spoke of how stressed the women were, due to their dire financial situation and many of these women had little to no idea of how to access Centrelink benefits. Cost of healthcare was considered to be a barrier by several providers, with Medicare bulk billing access was an important aspect of enabling access to providers. "*Cost is a barrier and, obviously, services that are free, or no cost, are going to be more attractive and enable people*" (SHSP manager). Many of the older women were reluctant/ or too ashamed to seek financial support as they had tried to manage on their own after their relationships had broken down. Often their husbands had managed the family finances. She also pointed out often women struggle to pay for medications as "*medications cost…so even if it's on a script, sometimes they don't have that six dollars available."*

Many of the women had lost or had fled from domestic violence without their identifying documentation or ID cards. Others had their ID stolen. As those

clients without a Medicare card are mostly unable to see a doctor, SHSP staff work with the women to assist them to access their identification and Medicare cards. Some GP services will accept women who've lost their healthcare and Medicare cards, which means the GP service needs to contact Medicare to sort out billing. In the inner-city, the Homeless HealthCare GP will see clients without a Medicare Card.

"*Cost is a factor for many, because even if it's reduced cost, greatly reduced cost, very often they don't have any cash on them so they can't afford anything. They find it difficult to budget for the future… so that they can save up for those glasses …or whatever a thing… so that becomes a factor"* (SHSP manager).

6.2.8.3 Healthcare providers' perspectives

All health providers interviewed agreed that cost is a *"huge barrier*" to medical services. This includes very limited access to psychologists; whose services are not free but through Medicare bulk billing arrangements and where there is often a gap fee required. "*We get time after time, after time, after time, people coming in saying, "I tried to access the bulk billing. I tried to access this. I tried to access that".* A nurse discussed how women can get a mental health plan from the GP for 10 free sessions but are faced with finding someone who will bulk bill and virtually none of them do, so often women are faced with an $80 bill in top of what Medicare will rebate them for a visit. *"There's a gap, and there's only ten sessions, and some of these women have very complex issues."*

Cost is a real problem mainly for people who don't have Medicare cards, particularly to access to specific tests such as MRI or CT, and that there nowhere in this city except the public health system that provides bulk billed CT scan or MRI without some special arrangement being made through primary care providers such as Homeless HealthCare. Women can access free bulk billed eye testing every 2 years under the Medicare system but then they can't afford the spectacles.

A medical practitioner working in general practice said much of their work is paperwork which comprises assisting homeless people with applications for housing and Centrelink pension / social security applications. Healthcare

providers also recognised there are financial barriers where some women can't afford the $6.30 fee to cover the gap of a pensioner discount for some medications. HHC and the Street Doctor carry a stock of urgent medications which they will provide to clients who are unable to get to a pharmacy, and *"that for clients who haven't got any money, we get grants to assist with the cost of their medication."* Some of these costs are also covered by private donations. Where possible, HHC and the Freo Street Doctor encourage Aboriginal clients to register with a local GP practice, to have access to prescriptions for free medications through the "*Closing the Gap"* Federal Government funded program.

The need for affordable and accessible dental services stressed as a health priority by healthcare providers *"a lot of them have dental issues"* (medical practitioner). Providers spoke of the limited access to affordable dental care for homeless women where *"women seek a dentist when they have broken a tooth or abscess, they'll just go to get that bit fixed and then they're out they won't follow up with other teeth"…"when you don't know where your next meals' coming from, your teeth are way down the list"* (psychologist).

6.2.9 The need for ongoing psychosocial and healthcare support once housed

While seen as the fundamental solution for homelessness, all those interviewed agreed that while housing was an essential step to recovery, the vast majority of those who have been homeless need ongoing support for mental and physical health care if the cycle was to be broken. Women spoke of how staff at all locations had helped them initially access social security, healthcare and accommodation. The importance of continuing to support women once they have found accommodation was stressed by providers and that women need to be supported to re-introduce them back into society and particularly to provide ongoing counselling and support. Providers had found that women remain vulnerable for some time when all those factors that contributed to their homelessness in the beginning can re-appear.

6.2.9.1 Perspectives of the women participants

The women said their health generally improved initially after moving into transitional and longer term accommodation, but many still struggled with health needs. Many of the women were on numerous prescribed medications for which they required support to maintain.

Participants residing in transitional accommodation reflected on how the hostel staff were helping them become stronger during the year in which they were able to stay at the hostel and of how the staff were helping the women plan for when they leave, helping them with financial planning and working towards finding permanent accommodation. The women all felt this was crucial to their health and well-being and were grateful for the assistance provided by the case workers *"they help you here, fantastically….brilliantly."* Some of the residents were also undertaking study and looking to how they might find a little bit of part time work.

Whilst overwhelming the women spoke of how they appreciated the support while they were living in transitional accommodation, some of the women realised that even though they now had somewhere safe to stay, they required more support than staff could provide. For example, there are no staff at night at the hostel and one suggested that there needs to be someone to check the women living at the hostel, *"to go over and check out whether she's alright... at night, because she's had a few falls."*

One woman commented how her case manager was helping her plan for the future, including referring her for further financial advice. An example of how staff assist women with future planning includes having the women sign 12 week lease to assist them with future rental applications *"every 3 months we sign a little lease – but we can stay here a full year… it's just getting you back into society, so you signed a lease, so you can have a reference … so if I wanted a lease, (my case worker) can say "she's been living here, for a year, and she's been on a lease, she's followed her lease. She's paid her rent so having that sort of helps you transition back into the world again."*

A woman who is now settled into a small rental unit stressed the value of having ongoing support from the Ruah Street to Home Program whereby the case workers *"Come out every Monday night to see me…it's so valuable I just look*

forward to Monday nights." She now has stable accommodation and good medical support, having slept rough for years on the streets and in her van, where she was unmedicated with a bi-polar disorder.

6.2.9.2 SHSP Perspectives

There was general agreement that once housing is provided, women who have been homeless still require some level of support including when they are accepted into transitional accommodation. For example, women who secure a room in the transitional accommodation hostel need to be assessed as to whether they are at risk to themselves or others as the hostel is unstaffed at night. A case manager commented that the transitional housing works well for many of the women residing where workers support them back to feeling strong and strong enough to be self-sufficient in their lives. However, it was not anticipated when establishing this relatively new service is that these women require much more support than was originally anticipated.

Providers noticed that once women get to transitional accommodation after sleeping rough, they appear to be able to prioritise and take better control of their health. This includes being able to better manage their medications where they would have formed a relationship with a local pharmacy, and they might have medications Webster packed and somewhere safe to lock their medications. …"*whereas before it was just a disaster ... it was chaotic... it was ad hoc ..."* SHSP providers felt that the provision of ongoing support was crucial to support linking women to social security. A manager of an emergency shelter in the city for men and women suggested "*when someone goes into a house, because they have led such a chaotic lifestyle on the streets, then having to conform to living within a house …they need support around linking in with other social supports."*

Several SHSPs stressed that whilst more long-term housing was definitely required, it had to be supported *"to reintroduce women back into society."* Providers stressed the importance of continuing to support women once they have found long term accommodation. Once they exit the transitional hostel service *"they're kind of on their own, and all those things that contributed to their homelessness in the beginning …can make a reappearance … when you identify someone who has been quite vulnerable, you can't just put them in a house and*

say, "see you later" … they need some support there to continue." One SHSP manager noted that family can be a huge support for the women but can also be a stressor that may re-emerge and may have led to the woman's original homelessness, where families came and overstayed in the house and the woman was evicted.

The women need follow-up and if not, case managed, at least have regular contact to sustain them. *"Simply because when you find long term accommodation it doesn't take away all your issues that caused the homelessness – the depression, your isolation, your other financial problems … it doesn't get solved just because you've got permanent residence."*

6.2.9.3 Healthcare providers' perspectives

The need for ongoing support once housed was raised continually in the interviews with both SHSP and healthcare providers. Health providers recommended that ongoing support should incorporate the provision of healthcare and specific services to support women who have experienced trauma and abuse, and a need for supportive services and a need to develop and/or re-connect with social contacts and networks once women (and men) were housed.

Health providers had found that after the initial relief of finding secure accommodation has been addressed, women often became depressed or simply did not have the capacity to manage living independently and that there is a need for… "*support services in place for after people are housed, who actually support people to remain housed*…*"sometimes the hardest time for some of the women is not necessarily being sleeping rough, it's the trauma that comes to the surface once they're housed".* Healthcare providers stressed that continuing primary healthcare was needed …"*We're finding that after-hours is the time when people fall apart"* (nurse).

The healthcare adviser suggested, *"we see a lot of women where there's chronic homelessness…they are now entering their fifties and sixties, but they probably have been homeless for a large proportion of their life, in and out of accommodation and very, very difficult to house, but they don't have the skills to keep them living in stable accommodation, and the supports that are required."*

A medical practitioner suggested *“there is a need for supported accommodation, including supported healthcare... it goes hand in hand.”*

The psychologist suggested that women have experienced domestic violence require ongoing counselling support *“We need to let women know that ‘Later, when you’re a bit more stable, there’s somewhere you can come and have some counselling’ as they can be still quite lost.”*

All of the interviewees indicated that “housing” is not just house or a roof over your head and that a model is required where the house is just one part of it that encompasses an ongoing interrelationship that involves social interaction which enables the women to develop confidence and the ability to manage independently and that women need ”*long term stable housing, plus long-term wrap around support.”*

6.3 Summary of key findings

The findings from interviews demonstrated that the providers highlighted very similar issues as those identified by the women.

Accommodation and feeling safe was identified by the women as their major factors underpinning their health. They also said that their health had been and remained affected by their experience of homelessness. This was supported by providers who stressed accommodation was fundamental to the women’s health and their return to more normal lives. The women’s experience of domestic and family violence had contributed and continued to affect their mental and physical health, with providers reporting trauma and abuse as common factors that underlay the health issues in older homeless women. Women’s relationship with their children was crucial to their health and many had been estranged from families.

Providers had observed that homelessness creates a painful disconnection and loss of family, which is a major issue for these women. Many of the women had major mental health concerns which they had experienced at the outset of their homelessness experience or had developed as they spiralled into worsening circumstances, which in many cases culminated in their living in their cars and then onto the streets.

Providers considered mental illness was a major health need for older women experiencing homelessness, and several suggested that older women's mental health issues may have arisen from a life span of chronic trauma and/or from domestic violence. Most women said they had major mental health concerns and also multiple physical health conditions including exhaustion, insomnia and pain.

Providers identified that women presented with a complexity of health needs, requiring support to manage their multiple and overlapping mental and physical health needs, suggesting this was further compromised by a number of inter-related factors. These included the women's health not being a priority for them, their being too depressed to deal with their physical health problems, not seeking healthcare until they were really ill and then presenting late to the acute health system.

Cost was a barrier which limited many women's access to health care, including the availability of bulk billing GPs, Medical Specialists and Allied Health. The cost of medications was also an issue, especially where the women had been prescribed numerous medications. Women's ongoing financial distress impacted and continued to impact their mental and physical health. They were initially unaware of how to access financial support including social security support. The importance of continuing to support women once they have found accommodation was stressed by providers, and that women need to be supported to re-introduce them back into society and particularly to provide ongoing counselling and support. Providers have found that the women remain vulnerable for some time after being housed, when often all those factors that contributed to their homelessness in the beginning can re-appear.

In addition to the issues raised above in the key themes, a number of other "system" issues relating to the women's experience of homelessness and access to services were identified. These are discussed in the next chapter.

Chapter 7

Interaction between health and homelessness

7.1 Complex interplay of factors and homelessness

During the semi-structured interviews many issues and comments raised by the women (and the different service providers) reflected the complex range of interacting factors that impacted on their lives and well-being. As such, they did not align well with the more unidimensional themes described in the previous chapter as they described a wider interplay of issues that affected their health needs, and ability to access social and healthcare services.

For example, many of the women reported that their experience of homelessness included a mix of relationship breakdown, trauma, lack of safe housing, financial difficulties and physical and mental health problems, all of which further affected their health. "*I've had two children…I was a victim of domestic violence. The combination of family breakdown and mental illness led to me being homeless for five years, I wanted to get away cos I felt really rejected. So many things happened, including I was sexually assaulted* (on the streets) *…after I'd been on the streets for two years, my sister bought me a van. Mum and my kids didn't know where I was, I just said I was going camping on my own."*

Similarly, healthcare providers also spoke of the challenges they experienced providing healthcare for women experiencing homelessness. In the words of one nurse *"complexities, complexities ... complexities, and problems"* whilst another healthcare provider reiterated *"there is no simple thing as a simple answer".* When describing the health needs of the women they had seen, these varied due to a range of factors such as the women's medical history, where they lived, how long they had been homeless and the circumstances that had contributed to their homelessness.

One medical practitioner had observed "*it's really hard, because the reasons can be complex, and something that's developed over quite a long time where they've had very unstable relationships in a situation for a long time, and then a few factors come together, which mean that they can no longer find somewhere like a*

couch surfing, or someone's taken a VRO out against them, or something has caused them to just sort of fall off the cliff… you've got different groups of women."

With this in mind, and with the need to utilise all the provided information to develop potential "solutions" (in the form of recommendations; see Chapter 8), the themes were mapped into broad categories to help reflect their cross-interaction and to help capture the other raised points that were too broad to be confined within a single theme.

Referring back to the "Behavioural Model for Vulnerable Populations" developed by Gelberg (Gelberg et al., 2000) (see Section 3.1) that informed the design of this study, the three 'population characteristics' of Predisposing, Enabling and Need were modified to the categories Contextual, Healthcare Need, and Barriers to Access. These categories better aligned with the questions used in the study that draw from the work of Kertesz (Kertesz et al., 2014) that more closely examined health service utilisation than Gelberg's model by examining four key areas of:

1. Patient/ Clinician relationship,
2. Cooperation amongst clinicians,
3. Access/ Coordination,
4. Homeless specific needs.

To this end, the nine major themes were grouped into three broad categories as shown in in Table 7.1:

Table 7.1 Classification of major themes into broad categories

Category	Major theme
Contextual issues	Accommodation and safety
	Women's experience of trauma and abuse
	Impact on a women's health due to her inability to fulfil her role as a family nurturer
	Financial security
Healthcare needs	Mental health
	Complex interaction of physical and mental health needs
Barriers to access	Cost of healthcare services and pharmaceutical
	Stigma shame embarrassment and the fear of being judged
	Need for ongoing support (including psychosocial and healthcare support) once housed

7.1.1 Contextual issues

As the primary focus of this study was to explore the health needs of older homeless women, primarily their need for safe, secure housing, the fact that they often had experienced a long history of trauma and abuse, the importance of a connection to family and the need for financial security were all regarded as largely 'contextual'. This is due to the fact that whilst they may have underpinned women's health needs and impacted on their health outcomes, these factors had an additional complexity in that they were often inter-related and exacerbated the women's' health and furthermore could be not necessarily be easily addressed. That said however, these factors also provided a richness to the women's situation and the comments collected under the heading of 'healthcare needs' and 'barriers to access' needed to be viewed through this lens.

7.1.2 Healthcare needs

Interviews identified a complex inter-relationship between homelessness and health that was often mirrored in both the mental and physical health needs of the women that resulted from years of physical and emotion abuse and loss of family connections.

7.1.3 Current health needs

7.1.3.1 Perspectives of the women participants

Overall, the women participants had said that not having safe and secure accommodation and financial security compounded both their mental and physical health and that their health continued to be affected by their experience of homelessness. The women also stressed the relationship with their families was crucial to their health. The women said that their main health needs included both their physical and mental health, with most women experiencing fatigue and exhaustion. The women said that they required a range of prescribed medications to manage these health conditions. Whilst the women were aware of the need for preventive health, this was not a priority for them as they endeavoured to adjust physically and psychologically to their becoming homeless and cope with their more immediate health needs.

7.1.3.2 SHSP perspectives

Similarly, the providers reported that women under their care had presented with complex mental and physical health needs, exacerbated by their experience of homelessness. They had seen many women present with inter-related mental health and AOD issues. They also stated that women experienced the significant impact of past trauma, including grief about their former life. They had witnessed how the stress of homelessness further compounds the ageing process. From their perspective, the women's major physical and mental health needs included: exhaustion, insomnia, anxiety, depression, heart disease, diabetes, osteo-arthritis and dental care. Gynaecological problems, especially the symptoms of menopause, were particularly problematic for older women sleeping rough.

7.1.3.3 Healthcare providers' perspectives

Health Providers similarly identified that women had multiple overlapping physical and mental health needs. They had found that the stress of homelessness exacerbated and compounded mental health needs, and that alcohol is used by many homeless women as a coping mechanism. Many older women experiencing homelessness present at homelessness services having experienced physical trauma and mental abuse. Diabetes is a common physical health issue, as is physical exhaustion. Virtually all providers stressed the need for ongoing dental care. Women's specific health needs included sexual health and a need for female specific mental health counselling services. Healthcare providers were aware of the need for preventive health, but more urgent health needs prevailed until the women were accommodated and their health stabilised.

There is limited access for homeless people to allied health including dental, which is a major need for women experiencing homelessness, and said that from their perspective, basically dental care service in Perth is ad hoc, with long waiting lists and expensive. They said that for people on a Centrelink, or any sort of healthcare card or pension, dental care is still a 'user pays' system, and that although women can attend the Oral Health Centre of WA for a free dental assessment, they are unable to access free dental care. Providers agreed that free dental care dental is practically non-existent in Perth. At the same time, there is a

free dental service provided within the community centre at St Pat's in Fremantle which provides a valuable service to people experiencing homelessness.

HHC has an arrangement with a private radiology service to see HHC patients. Most radiology clinics bulk bill people with healthcare cards but HHC specifically recommends a specific radiology service because they are aware of homeless patients and try to help them, and the service is easily accessible by public transport.

Pharmacies were cited as beneficial to homeless women, especially those in Maylands and East Perth.

7.1.4 Impact of homelessness on health

7.1.4.1 Perspectives of the women participants

The women said their health generally improved initially after moving into accommodation but that they still struggled with their mental health. They all noticed that where they were living had a major impact on their health, particularly those women who were living on the streets or in their cars. Women's previous experience of abuse including domestic and family violence continued to haunt them; many had become estranged from family which further affected their mental health. Their capacity to maintain their medications was an ongoing problem, due to cost and/ or being stolen. All women said they needed a dentist. Whilst the women felt that maintaining a healthy lifestyle was important, especially being able to manage stress. The lack of financial security remained a stressor as did the stigma, shame and embarrassment they all felt as a result of being homeless at their (older) age and not having a home for their children and grandchildren. For some women it was more embarrassing to admit they had a mental illness than being homeless and this precluded those seeking help.

7.1.4.2 SHSP perspectives

SHSP providers generally agreed that the impact of the recency and duration of a women's homelessness impacted on her health, but this depended on a range of inter-related factors. The providers agreed that those women who had recently become homeless, presented in better health. However, these women tended to

be more stressed and in a state of shock than those who had been homeless for some time who may have been able to access services. The length of time that a woman experienced trauma and abuse was seen by many providers to have a greater impact on her health than the length of time that she had been homeless. Where women were living impacted significantly on their health, with those living on the streets the most vulnerable. Whilst trauma and abuse were common underlying and often contributing issues, providers agreed that there was rarely one cause of homelessness for older women, but rather a complicated range of inter-related financial, emotional and physical factors. Providers had found that that women need practical support to assist them with managing their finances and planning for the future.

7.1.4.3 Healthcare providers' perspectives

Healthcare providers stressed there is a complex inter-relationship between health and homelessness and found that the reasons for a woman's homelessness were complex and had generally accrued over time. Women's experience of trauma and abuse significantly impacted on their health. Many of the women had become estranged from family which further affected their mental health and feelings of loss and abandonment. Providers observed there were generally differences in the health of the recently homeless compared to the longer-term homeless. Women's previous experience of trauma and abuse had a significant negative impact on their health. Women sleeping rough were in the worst health of women experiencing homelessness and at risk of further abuse. They observed that women who were living in survival mode tended to put their health needs last until a medical crisis arose. The sooner the women were housed, the less there was a longer-term negative health impact. Healthcare providers agreed with SHSP that women are highly anxious until they find accommodation, and that once their anxiety and exhaustion settles, then underlying issues start to emerge, especially their history of past trauma and abuse.

7.1.5 Barriers to access

In addition to issues captured within the themes, a range of other factors were raised through the interviews that impacted on how the homeless women could or would access healthcare services.

7.1.5.1 Ability to negotiate the system

Many women reported difficulties, especially in their early stages of being homeless of knowing where to access support for housing and other services. This was even more challenging for migrant and Aboriginal women where ethnic, cultural and linguistic challenges were more pronounced. That said, it was also evident that the SHSP staff played a significant role in assisting the women navigate the complex network of government and healthcare services.

7.1.5.2 Perspectives of the women participants

Participant women continually expressed how unaware they were of accommodation and other services for older women and they almost had to stumble upon them. For example, one woman said *"So, I am panicking, I'm like, I can't go to the street. It's getting cold. What am I going to do? So, I went to a place in Cannington called, um Something Care, and they said "No. We can't help you because you've already been in Australia for so many years. We help people who have been here for five years"* (Refugee woman living in transitional accommodation).

Another woman managed to find her own way, having moved from the country to an untenable living situation in caravan park in Midland, describing how she then "*saw City Farm from the train, and I thought, I'm going to have a little poke at that. So, I had a little look around and then I saw the big, multi-storey building and then they sort of told me they had a women's hostel just down a few blocks. So, I filled in an application from there and then I got a doctor's referral here, it took a couple of months"* (woman living in transitional accommodation).

7.1.5.3 SHSP perspectives

Two SHSP managers spoke of how staff spend many hours trying to assist women who have lost their ID. Staff work collaboratively with the Transport Department to facilitate women acquiring a "proof of age" document/ card for ID purposes.

There was general agreement that many of the places for the homeless, including the day centres, could be quite confronting for some older women. *"Women often have to go into housing where there's men housed as well, maybe on a different floor, but there's still a lot of men around, and if you're vulnerable, they feel very threatened, it becomes very overwhelming…there's not many supported accommodation places."* There are limited long term housing options available to women which have long wait lists that so it may take years before they get their house. This makes the women feel even more insecure, especially if they previously had a stable life …*" they're not street savvy…. they don't have those skills."*

There was an evident need for aged care specific accommodation for some of the women. A healthcare adviser explained that *"The only way to access Aged Care in Australia is via the My Aged Care gateway phone and website service. Once contacted, they explain the options to the person and explain the need to have an ACAT assessment. Not knowing about My Aged Care, either the website or the phone means that access to aged care becomes an issue. For a homeless person sleeping in the back of a car, if they have no family, at all and they are homeless, and they're living on the street, sleeping rough, they will have to have someone/ an agency help them to have an ACAT assessment if they need to move into aged care. In other words, access to aged care is inaccessible unless they're assessed by ACAT."*

7.1.5.4 Healthcare providers' perspectives

A medical practitioner spoke of the difficulties finding culturally appropriate places for the specific subgroup of Aboriginal women who have high or reasonably high needs. She provided the example of a 73-year-old woman who had been living mainly on the streets for whom she referred to the Salvation Army

crisis and supported accommodation service. This woman had been seen at RPH ED 11 times that month, simply wanting a bed for the night, because it was too cold, wet and dangerous for her to be out on the street… *"We really, really struggled and I had to personally speak to reassure the manager, that we thought that she would be okay and they're giving her a trial…...She is so desperate to get off the streets ... she stayed there the first night and she was really happy… she just wants a safe place to live."*

7.1.6 Interagency communication, collaboration and coordination

The interviews with all participants highlighted the challenges and need for better interagency communication and coordination to support the needs of the homeless. Despite the difficulties, several services were making significant inroads to address these problems.

7.1.6.1 Perspectives of the women participants

One woman stated that *"everyone's missing the cog",* whilst another with long term illness and just coming out of hospital, said she found health services very *"disjointed."* Others identified the need to greater support in linking the homeless between the different specialist services and the healthcare system. One woman who had been sleeping in her car felt strongly about the lack of links between services: *"The system is not coordinated to coincide with each other. One on one person, it seems to be generalised, which is no fucking use at all. Pardon my French…. "there should be a centralised system – Centrelink, Medicare, health services, doctors, all being in one building, and it all being recorded. If you are unemployed you want everyone to know your circumstances, so you can receive the best you can."*

A woman who struggled to pay for her medication summed up her thoughts on how service delivery for the homeless could be improved: *"I think the full package should be done, not just bits and pieces… especially finance as well, because in my situation, I came from a full-time job, was able to afford certain things, I was renting a home of my own."*

There were several suggestions from women that agencies including employment providers, social security services educate their staff on how to better communicate with and assist people experiencing homelessness, and to understand the older women's capacity to meet some government rules and regulations: *"I'm on the streets and the employment providers, you're homeless, and they're wanting you to work …so, they refer me to xx… I don't know north of the river, so it took me three times to get there… I got lost… by the third time I finally found it. I did have my interview… a young male counsellor, and he was more involved with the paperwork "oh would you take this home and just write some things down…there was no understanding of my situation."*

Two women told of how they tried to contact Centrelink via their mobiles, but their limit ran out while there were on hold. However, Centrelink staff visit some of the homelessness services to provide advice to homeless people although many of the participants seemed unaware of this. Many of the women had never previously applied for social security and were appreciative of the assistance they were receiving from SHSP staff.

Another woman however had a very different experience after having been transferred from the country by Royal Flying Doctor Service after a domestic violence assault. The *"amount of help I've got here is unbelievable"* compared with living in the country where she *"did not get any help'* largely through the support of her case manager from the transitional hostel. She now attends Fiona Stanley Hospital who regularly liaise with the hostel, as part of their "Rehabilitation in the Home" program.

7.1.6.2 SHSP Perspective

Optimal communication amongst providers was regarded as central to providing ongoing support by the SHSPs with many developing good linkages and ways of effectively communicating with each other. In practice, however, this was sometimes difficult due to clients' reluctance to divulge information, particularly about their dependency or mental health issues due to fear of stigma, and their past history. These issues may have excluded them from an organisation in the past.

The transient nature of being homeless also compounded communication problems. A case worker in the older women's hostel spoke of a woman whom she was assisting to seek some support, who was sent a letter to her previous rental as that address was on the provider's system and not her current address. Having stable accommodation in which to receive correspondence from the hospital is crucial for accessing health services.

While some agencies agreed that being very protective of their clients' privacy could impact on the level of communication between agencies, many providers spoke of the need to collaborate with state and Australian government agencies, including WA Departments of Transport and Housing and with Centrelink. SHSPs can refer clients through to the day centres to the Centrelink community team that visits the day centres. This service, comprising specific Centrelink community engagement officers, reportedly works very well, providing an effective service to people experiencing homelessness.

One refuge provided an example of successfully developing linkages with other agencies and working effectively across organisations. The refuge staff also actively go out and meet with other service providers in the local area… *"it's part of who we are….we have a policy here that we need to know these people"* They also communicate with local police to assist them dealing with situations of elder abuse and sharing the details of support networks in the area for women in need. The arrangement of having Centrelink social workers coming to the refuge to assist women works well.

SHPS also work well with health service providers and described a range of effective partnerships and linkages, commenting that for clients the *"referral process is about sharing, letting them know where those services are, to get healthcare needs addressed."* and that ongoing communication between the SHSP and the health providers was a key factor in maintaining these relationships. A SHSP manager spoke of how effective it was having the mobile street doctor service visit the centre regularly, and how the staff at centre work in collaboration with the street doctor service …*"I think having clinics like the Street Doctor… I think that definitely helps in terms of being responsive to meet the needs of older ladies."*

7.1.6.3 Healthcare providers' perspectives

Healthcare providers also reported the need for better intersectoral collaboration with one medical practitioner suggesting better connections within the hostel and the aged care sector that could provide supported accommodation. *"Something like a hostel may actually be absolutely what they need, an aged care hostel because there you've got people who are more functional."* This includes acknowledgement that health and aged care needs are basically dependent on an ACAT assessment.

A nurse spoke of how helpful it would be if there was a single contact point *"How great would it be, you know, if there was just a unified system where we were able to say, 'There's a bed over here, and there's a bed over there'."*

It can be difficult for healthcare providers hard to follow all the different providers…*"continually entering the homelessness space…it's difficult to keep up with which agency is doing what and they often don't' talk to each other…it would be nice if they were all really coordinated…. they're all very well meaning*" (medical practitioner).

One nurse reflected … *"What I think that the biggest issue is, that there's lots of services in Perth for people experiencing homelessness, but they're just too disjointed If there was sort of like a bit of a unified approach, it would be phenomenal….I think that sometimes when we meet older women who are sleeping rough and we're just trying to get them to start with, we're just trying to get them a bed. It would be great if there was a much more sort of coordinated approach."*

There was general agreement from healthcare providers that fragmentation and lack of coordination between services creates a gap in service delivery and results in people being lost to the healthcare services they need. For example, as women move locations, they are required to find another mental health and AOD services in the next location/ area, and for women escaping domestic violence have to move location for safety and this means they have to find another GP. …*"it's a work in progress. I definitely feel like we don't talk enough. It's huge. I feel like as a whole, the agencies in Perth don't ... we all don't all share"*

and that in some ways that health services were competing against each other, applying for the same tender.

In addition to issues captured within the themes, a range of other factors were raised through the interviews that impacted on how the homeless women could or would access healthcare services.

7.1.7 Availability of female healthcare providers

7.1.7.1 Perspectives of the women participants

Many women wanted access to women's health services because with female health providers as they felt *"heard them"* as they *"understand female problems",* with many refusing to attend a service if there were no female staff. For example, one woman (Caucasian) lives in temporary accommodation service that has a visiting male GP, but she goes especially to an Aboriginal health service to see a female doctor which she has been attending since she became homeless. Several women participants had utilised the Women's and Family Health Service (WHFS) in Northbridge and spoke highly of the service *"they really understand",* finding the counselling especially helpful. Another woman who was experiencing peri-menopausal symptoms said she intended to go to WHFS for a consultation with a female doctor whilst another spoke of how important it was to her that Homeless HealthCare had female nurses *"out there on the streets."*

There were also several suggestions from women participants for only drop-in and overnight shelters, where they could access female counsellors, nurses and doctors. "W*e need more services that are designed for women that have women there… women counsellors… women doctors … you know…so they feel safe".* Another suggested a providing a mental health service where women can consult female doctors. *"I don't mean to sound nasty, but males don't understand a lot of the time what a female goes through. What a female feels. And if you have a doctor, a female doctor, you can relate, you can relax, and you can talk to them more."* A woman referring to her experience of menopause said *"I've had problems before I turned 51. I've been on the streets a long time ago… and it was very hard, a lady on the street",* whilst another woman who had lived on the streets until recently suggested it would be good if there were nurses who

go out on the streets and talk to women who are homeless and just offer to help. There were requests for more sexual health services for women experiencing homelessness *"there's women out there and they are more vulnerable than men. Because about a couple of weeks ago, at Beaufort Park, a lady got raped walking through there... a homeless lady."* A woman who had slept rough over several years said, *"I'm not saying it doesn't happen with men, but it's more likely to be a woman that's being sexually assaulted, because she's on the street, and most of them will go with a male just for somewhere to sleep."*

7.1.7.2 SHSP perspectives

Providers spoke of how many women who have experienced domestic and family violence and as a result have a fear of males. For example, *"we had a lady who needed to have her eyes checked but it was a male optometrist and you know, they get up quite close and they look at your eyes…she had to say 'Sorry. Can't do this' and had to walk out of the room. Finding a female optometrist can be quite difficult, after four or five attempts the case workers had a female optometrist see the client."*

Several providers were unaware of the services provided by WHFS but were endeavouring to find out more about the services, particularly for counselling. Other SHSP providers had regularly referred women to WHFS. Some Midland women were referred to the Midland Women's Healthcare for a range of services including counselling, cancer screening and anxiety/ stress management courses. Refuge workers also refer women who have been sexually assaulted to the Sexual Assault Resource Centre (SARC).

7.1.7.3 Healthcare providers' perspectives

Health service providers generally agreed that not having access to a female provider is a barrier to accessing healthcare for many women, particularly those who had experienced trauma and abuse, and that providing women access to a female health provider considerably enhances the likelihood of women accessing healthcare services.

The philosophy of WHFS is to work with women recovering from abuse and domestic violence. A psychologist suggested educating both women and health providers to be more aware that domestic violence is more than being physically hit but includes psychological and financial abuse. WHFS is running a small group for women who have fled domestic violence, and suggested health providers should attend similar sessions to understand *"this is what domestic violence is…getting good boundaries, how to be assertive, really common-sense stuff."*

7.1.8 Cultural and linguistically appropriate services

While most women expressed a desire for access to female staffed healthcare services, some also highlighted the important of these been culturally appropriate to meet their needs, although confidentially due to large family networks appeared to be a different challenge for some Aboriginal women.

7.1.8.1 Perspectives of the women participants

Some of the ATSI and CALD participants considered that finding a health provider who could maintain their confidentiality was important to them. Most of the ATSI participants and some non ATSI women used a metropolitan based Aboriginal health service which they found *"pretty good"*, accessible, and met their health needs including no appointment system and providing access to female doctors. Some of the ATSI women utilised both their local GPs, where they felt comfortable, as well as the doctors at the Aboriginal health service. One woman has been on the streets for a year, has been going to the Aboriginal health service for her medical prescriptions which she has dispensed at the chemist in East Perth. ATSI women also said they had found the Street Doctor and HHC accessible, helpful and culturally sensitive.

However, several Aboriginal participants reported that they were uncomfortable going to Aboriginal culturally specific services with one woman saying she was *"related to nearly all of them"* and felt *"intimidated"* as she didn't want to talk with the staff there about her confidential health problems. She said this prevented her from getting the kinds of health services she needed.

There were similar confidentiality concerns expressed by some of the participants from CALD cultures who were reluctant to seek assistance from services specific to their country of birth. This especially applied to women who had experienced domestic violence as they did not feel confident about maintaining confidentiality within the confines of those communities. Language was a barrier for one woman who did not speak English, who said she needed someone from her own country to go to the GP with her and act as her interpreter. However, she has now found a (female) GP who speaks her language and she is relatively satisfied with the service she receives.

7.1.8.2 SHSP perspectives

Providers highlighted the importance of having female providers for multi-cultural ATSI and CALD women, and the use of interpreters for communicating with women who do not speak English. Providers confirmed women's reports that some Aboriginal women were wary of accessing ATSI specific services due to their relationships with Aboriginal staff who work in these services… "*because everybody knows everybody and that's a huge one, and particularly around any counselling service sort of that they don't tell someone else."* Another provider said that Aboriginal women would rather not go to an Aboriginal service *"because they know half the people there."*

One provider had found from her experience that the literacy problem experienced by some of the Aboriginal community precluded them accessing healthcare *"From their perspective getting help can sometimes be so complicated that it's easier just not to bother."*

A SHSP manager also said she had found that older Aboriginal women's experience of pain and trauma, especially from the Stolen Generation, now affects these women's capacity to trust systems, including the health system. A manager of a community and homeless centre where approximately 25% of the client base are Aboriginal people. She said *"for Aboriginal women, there's a lot of factors … a lot of the women we see are currently homeless, or virtually homeless for most of their life. So, they've been in and out of accommodation whether it be Homeswest, or whether its temporary or transitional … there could be other factors … there could be families using this place… causing disruptive*

behaviour… so they lose their accommodation ... or it could be through their own abilities to cope and manage the living skills. A lot of drug and alcohol issues…and abuse and violence, so that violence has become part of their life – it's the strategies they use to deal with their challenges ... and it's so much part of their life… so you can't separate it out of the picture… And then of course there's the grandkids that they're looking after ... because family are so important for our Aboriginal clientele … you don't see them in isolation, you see them as part of a group or family structure." Another provider spoke of how she felt services were failing to address of the high proportion of Aboriginal people in WA experiencing homelessness *"we're not even touching the issue of Indigenous homelessness… and older women's homelessness … and elder abuse."*

Providers spoke of many incidents of partner, family and elder abuse that they had encountered in ethnic communities including ATSI and CALD. They suggested there is a gap in multicultural services for women in suburban areas as most of these are located in the Perth CBD.

"Language is a HUGE barrier" accessing healthcare for some women who do not speak English. Case workers expressed concern that some GPs do not use interpreting services for women from CALD backgrounds who do not speak English, due to the length of time this adds to the medical consultation.

One provider spoke of women of a number of Asian descents who were seeking assistance from homeless services who had been brought to Australia for marriage and had been abused and assaulted by their husbands. *"If they've walked out, can't speak English, so you've straight away got the language barrier."* A case worker also spoke of how at the refuge they work with many Muslim women, and how these women, for cultural reasons, cannot see any doctor as the provider needs to be Muslim and/ or female which limits their ability to access healthcare services including general practice. This worker described how women from CALD backgrounds struggle to cope in Australia after fleeing domestic violence. She described the situation of a Vietnamese woman who was currently living at the refuge, explaining that this woman had eight children, with five still living at home "*but she's like a child, her husband did everything, he paid the mortgage, paid the bills, just looked after everything, and now she doesn't*

know what to do. So, there's all these areas she has to be guided through legally, financially, her health. It's very difficult when she doesn't understand English."

7.1.8.3 Healthcare providers' perspectives

Healthcare providers were aware that language barriers, not having translators and a lack of culturally appropriate services creates barriers to health care.

Ethnic women experience difficulties when they become homeless as they're often separated from their cultural groups. If there's been domestic violence, they're not just leaving their relationship, they're leaving their cultural group. So, they're in another country, with another language, and different ways of being, and suddenly, they are on their own *"and their cultures can be very judgmental…. So, they're having to cut themselves off from their culture as well as their relationship."*

Healthcare providers said they were aware of an assumption that Aboriginal women will go to an Aboriginal agency, but they had found that many ATSI women were reluctant to go to these agencies, because *"everyone will know their business."*

WHFS provide culturally safe services *"we're culturally aware … so women feel completely comfortable here. it's one thing that women often will say, and it may not be that other agencies lack confidentiality, but they just don't feel safe."*

7.1.9 Arranging and attending clinical appointments

7.1.9.1 Perspectives of the women participants

Women who slept rough found maintaining appointments with GP practices problematic. One woman in Fremantle who had been homeless for several years and spoke of how she had not kept two appointments in a local GP practice and now that the clinic refused to see her again. She had found that the mobile street doctor service worked better for her, where it wasn't necessary to make an appointment *"so you're not missing appointments and getting kicked out of your GP's practice for it ... because when you're homeless you make an appointment and you think 'yep…no worries. I'll make that, No problem. I've got*

nothing else on that day', but shit happens, and you can't always keep a specific time and date … you just don't know from day-to-day... you don't know where you're going to sleep most of the time."

An ATSI woman came to Perth from the country *"to have my eye fixed at the hospital"* but she did not understand the details of her appointment *"the doctor told me I've got to be here, so I went home and packed up my things and cleaned up my house and gave my key up … I thought I was going to get my eyes scraped."* She ended up on the streets, still hasn't been treated but was being assisted by her case worker to access specialist care.

Another ATSI woman who also came to Perth for eye treatment said she had been told she would get a letter from her hospital about when to return for follow up, but the letter never came, and she never went back to the hospital and now she is blind in that eye.

7.1.9.2 SHSP perspectives

SHSP agreed that the medical and hospital appointment system creates significant barriers to healthcare access for homeless women which is compounded by the hospital sending appointments through the mail. A case worker spoke of one woman who was scheduled to have dental work as she had most of her teeth missing but missed her appointment at the dental clinic as she was unable to be contacted and another woman who had lost her eye due to trauma needed to be seen at RPH, she had come down from regional area but had not been seen in 3 months because the hospital was unable to get in contact with her.

As a SHSP manager explained, women remained stressed by their experience of becoming homeless *"They're stressed… they can't get their lives in order, so … a lot of them don't even know what day it is … the day to day things we take for granted, they don't have the personal resources for that … a lot of them experience emotional stress and this can impact on them remembering appointments."*

The SHSP case workers try and assist with women re-connecting with essential services, helping them make and prompting them and reminding them

keep appointments. *"They've got these essential appointments, but they're not contactable … many of the women don't have mobile phones, a lot of them don't know how to use a mobile phone and a lot of them don't have fixed addresses... or they're moving around … because a lot of them have moved from transitional accommodation to crisis accommodation to another crisis, to another crisis."*

Providers spoke of the need to simplify the process for women to access to a health provider including the paper work and the wait time *"chaotic life styles making it difficult to keep appointments … if they could just walk in there and there was someone kind who would just chat with them for five minutes ... and find out what they need ... then that would be different to 'oh sorry. You'll have to wait for 3 weeks for appointments, and you can fill this form'".* Many of the women have literacy problems, some of whom have lost their literacy skills through the stress of the homelessness experience or due to their mental health issues, and/ or they have vision problems…. *"they're so stressed… they often don't know how to read or write but don't want to tell anyone that"* and yet *"if they approach some healthcare service, they're immediately told to 'fill in this form'."* Additionally, these women have no computer skills which further limited their access to support services.

Providers stressed that support services need to be aware of how traumatised many of the older women have become due to their homelessness and the crises that had led to their current situation…*"they are so traumatised, that if you ask them to go to the computer and fill in whatever, they can't do that ... so it makes it hard for them to follow rigid procedures of healthcare systems ... I think that's why they need to have different systems to deal with different people."*

7.1.9.3 Healthcare providers' perspectives

Public hospital outpatient department appointment system provides a major gap in service delivery for people and women experiencing homelessness. The system of sending letters to No Fixed Address (NFA) to tell people where their appointment is, and then taking them off the waiting list because they don't turn up for their appointment. A medical practitioner spoke of services where they refer clients to the outpatient clinics…"*We ring the hospital, they'll give them appointments, when even they haven't turned up, this happens all the time, still*

don't turn up. So, you try your hardest we get feedback and letters. And generally, it's that they haven't turned up" (medical practitioner).

"In terms of hospitals. it's very difficult for things like outpatient services because they are very inflexible so, for example, they'll want someone to turn up to a dressing's clinic next Tuesday at 9.30am in the morning and that can be quite impracticable for the person. They may not understand when next Tuesday at 9.30am is…or have a phone. So, you need to replace that with things like a caseworker taking them or a service like Homeless Healthcare and a drop-in clinic reminding them" (medical practitioner).

7.1.10 Staff awareness

7.1.10.1 Perspectives of the women participants

Two of the women who had lived on the streets suggested there is a need to raise awareness of the number of women experiencing homeless as well as better understanding the needs of these women, and that services providers need to *"get out onto the streets more and they would see that there are many more women out there than commonly thought".* One woman in the inner city reported that she had seen a lot of multicultural women as well as Aboriginal women on the streets of Perth. Another woman had noticed increasing numbers of homeless women in Fremantle over the years she had been on the streets.

An Aboriginal woman suggested *"I think they should have a go between. What do you call it? Liaison officer … to prepare them for where they're going… there should be a lady they can trust."*

There was stigma and a lack of understanding evident to the women in terms of accessing mental health services. Two of the participants who had positive experiences with mental health services suggested that the services such as they had received could help other women including finding a psychiatrist and a psychologist they could relate to. One woman suggested the need to "*change the stigma from mental…just use another word.*" There was a suggestion from one woman that a group such as Act Belong Commit (ABC) engage women…. *"to give them focus… when you've lost everything, you've got no focus… if you've just*

got one little glimmer of focus on something …just one little thing, even if it's just for one hour a week you're going somewhere, that focus builds and builds."

7.1.10.2 SHSP perspectives

SHSP commented on the difficulties and distress that homeless women feel having encountering health system requirements to fill in forms and commented that the paperwork seems to be increasing. A support worker believed that reducing the paperwork would be the "*number one"* means of improving homeless women's access to healthcare, and that simplifying the process make a *"massive"* difference … *"if people could just walk in to a health service, like Women's Health around the corner and there was someone kind who would chat to them for 5 minutes and find out what they need."*

A SHSP suggested that one of the first steps would be to raise community awareness of numbers of older women experiencing homelessness, *"to highlight the invisibility of older women's homelessness"*. One manager spoke of the common perception that there are not many older homeless women, which is due to their not being seen on the street with other people experiencing homelessness. *"I think for older ladies, maybe it comes down to identification... we don't see a lot of older women who have come because their partners have died, and they've lost their housing… now I've got to believe they are out there…"* (SHSP manager).

"Obviously, the street is the absolute last resort. Women will be in their cars, they'll be couch surfing, they won't be identifying as homeless. They're just staying with somebody for a while, staying with friends, staying with their children …until their welcome wears out". A SHSP manager said, *"they may be house sitters but in actual fact, they're homeless"*, explaining that many of these women work as *"housekeepers"*, while many others *"pet sit"* when people go away, intermittently staying in cheap Bed and Breakfast places or back packers accommodation or caravan retirement villages.

A constant theme throughout the research was the stigma and judgment attached to homelessness. Interviewees agreed that education is required for healthcare providers and the broader community so to enable them to understand why people experience homelessness, to *"unpack the myth of*

homelessness", that *"it's not a choice – it's the layers beneath that, why they have become homeless, what has contributed to the reasons behind that.* Suggestions included needing to create safe place where these issues can be explored, where people can have those conversations and having support to assist this process. *"unless you walk a mile in a person's shoes, you don't know what it's like."* (SHSP manager).

7.1.10.3 Healthcare providers' perspectives

Nurses and medical practitioners suggested there was a need for healthcare providers including GPs and Allied Health better understand how people experiencing homelessness could access Medicare bulk billed services *"It's a complicated system and it's not just the women who don't know how to access the social security system, many of the providers as well don't know"* (medical practitioner).

There is a need to enhance GP's awareness about homelessness services including where these service are and what they provide *"it's difficult, because there are a lot of GPs and there are a lot of homeless services…. it may be useful to put together some sort of a 'homeless page' of some sort, with different references on it on the net (not on paper)"* (medical practitioner). This would facilitate the GP quickly identifying housing, emergency housing and other services, then ring the contacts, noting this web page would need to be continually updated.

Healthcare providers felt that generally, health staff had a limited understanding of the complexities facing older women experiencing homelessness. As a medical practitioner explained *"The longer you're on the streets, the more drug and alcohol problems, mental health problems, and physical health problems you have.*"

The education of hospital and primary healthcare staff was highlighted by health service providers. A medical practitioner considered that within ED, some staff feel that *"homelessness is not a medical problem, it's not a hospital problem, it's a social problem … there have always been consultants who are much more compassionate but feel helpless and this is true of many staff. We see ourselves*

as people who can help, and this is all of the staff, nursing and medical... and that we have a power to be able to do that, but if you're faced with somebody who you don't have the power to help, by your own skills, then it can turn around into a negation of that, which comes out as anger, frustration, judgement, which is actually just an expression of helplessness. I think that some of it is a lack of self-insight as to why certain patients, you find difficult, frustrating, the other thing is that if you ask people, in a profession to do something that they don't have any ability to do, then they will try and reject those people in favour of the ones that the ones that they can do something about."

Another medical practitioner supported this theory in that healthcare providers may feel inadequate and unsure what to do or how to help, and have high expectations that, as a health provider, they should, *"You can't fix what's going on for a homeless person in single consult… can't make dramatic changes. You are not going to move them from street homelessness into a Department of Housing place in that first consult …It's not that most GPs don't like homeless people or women, it's because they feel helpless in the face of them because it's just too difficult to deal with, and it's also quite outside of the area of expertise that they can easily deal with in terms of the networks. So, it's easy to refer someone to a specialist for a medical problem, or to send them to a psychiatrist, or a psychologist but in terms of trying to help them to find somewhere to live, no experience. I think there'll tend to be, with many, a sort of withdrawal, which I imagine most homeless women recognise."*

She compared the management of homeless patients with complex needs to when she was a junior doctor working on the general medical wards where elderly patients with very complex needs were poorly understood and difficult to manage *"but put them onto a geriatric ward, which has multidisciplinary teams, home visits, continence advisors, OTs, physios… they are there every day … there's absolutely no problem with them at all, so it's what you've got, what you've got in terms of tools to help that patient, and when you've got the right tools, even seemingly, the most complex, difficult patients, actually become every day standard ...and that, I think is what a homeless team is designed to do, is say, 'Okay, that's a problem that we've got a solution for.'"*

7.2 Suggestions for improving the health outcomes of older homeless women

During the course of the interviews, participant groups all proposed ways in which healthcare services and health outcomes could be improved amongst older women. While some of the points may have been raised earlier in this chapter, recapping on these and adding them to other suggestions is an important step in the consideration and development of potential recommendations leading into the Delphi Expert Panel process.

7.2.1 Addressing the barriers

While challenges in communication, access, integrated and culturally appropriate healthcare services were clearly identified and remain a barrier to receiving healthcare for many homeless women, examples of health services that target the more marginalised sections of the community were also raised during the interview process.

7.2.1.1 Perspectives of the women participants

Having access to accessible and affordable (free and on site) and non-judgemental health services was important to the women participants. Several of the specialist homelessness services have a visiting primary health service on certain days of the week including the Homeless HealthCare[1] and the Fremantle Street Doctor services[2]. St Pats[3] provide their own free health clinic and the Freo Street Doctor team also visit the centre. One woman spoke of how St Pats *"Made me realise I'm not alone… St Pats is the only place I've accessed in my life that has done so much for me as they have done".* Another woman reflected *"We need more people like the Street Doctor who are willing to take you at your word, to believe your story, not so much your word, but to believe your story and*

[1] Homeless HealthCare is a specialised multi-site General Practice that provides primary healthcare and support to homeless people including mobile outreach clinics at drop-in centres and crisis/ transitional accommodation facilities. HHC also runs daily clinics at its premises and delivers in-reach GP service at Royal Perth Hospital (RPH).

[2] Freo Street Doctor is a mobile primary healthcare service that provides easily accessible healthcare to people experiencing homelessness in the Fremantle area.

[3] St Pats (St Patrick's Community Support Centre) is located in Fremantle and provides a broad range of support services including a comprehensive health clinic, a free dental clinic, direct on-street assistance and advocacy a day centre.

what's going on…"finding places like this you don't feel so isolated…I did feel isolated a week ago…I felt like I was the only person who was homeless…. I've been seeing the street doctors for the last few weeks, but I think they're awesome, bloody awesome."

Another woman now living in rental accommodation with the support of the Street To Home Program[4] said she believed that the doctor from Homeless HealthCare had effectively saved her life after she became homeless again and was self-harming and not talking her medication, *"because I used to see him a few years earlier when I got into the Homeswest accommodation …then I just sort of got lost" … he got a shock to see me again, and hear that I was homeless.. It was him and the Ruah staff that booked me in with Street to Home."*

7.2.1.2 SHSP perspectives

SHSPs considered that health services for older women experiencing homelessness in the Perth metropolitan area varied. They cited that services were most effective where SHSP's were able to develop working relationships with local providers or have primary health services provided in-house. For example, St Pats provide their own free primary health clinic, conducted by Silver Chain with registered nurses. The Freo St Doctor provides an on-site Primary Care service on set days of the week with the van parked out the front of St Pats. Women can also access the mobile GP service at St Pats as well as at several sites throughout Fremantle *"There's actually a good range of health services and health supports for the ladies who come here"* (SHSP manager).

7.2.1.3 Healthcare providers' perspectives

Attempts to address some of the common criticisms and complaints raised by homeless people has led to the establishment of the RPH Homeless Team project[5]. The medical practitioner working with this service explained that this was *"non-judgmental." …"it sounds a really terrible phrase, but we see everybody*

[4] Street to Home is an interagency, integrated response to the accommodation, general health, and other support needs of people sleeping rough on the on the streets of Perth.

[5] RPH HT is a collaborative team approach between RPH and HHC which aims to improve health outcomes for homeless patients in hospital, improving discharge planning and linking them with community- based services to address their underlying health and social needs.

others have rejected because they're either too complex, and/or they cannot address their health needs, so we just don't try and address everything at once, we just chip away at what we can achieve." "If you then have put a homeless team into a hospital, people say, "We have a homeless patient, I don't know what to do with them, but we have a Homeless Team that could come and see them ...and they can help the patient." Having that access to the homelessness services is crucial and she has found that hospital staff start to relax about difficult patients that they don't know what to do with, because then they actually have a *"pathway, that there's something that can be done*. *Theoretically hospital staff will understand that patients are not going to get well if they're living on the street, but they don't know what to do, even hospital social workers don't necessarily have good networks. The Homeless Team comes in, and starts to talk frankly, and openly, about the homelessness, and what can be done, for the patients, it's often an immense relief because they're worrying… "What am I going to do ... once they discharge me? How am I going to manage on the streets with a cast and a pair of crutches?"* (medical practitioner).

A nurse who works with a mobile outreach healthcare team said *"People tell us things that they've never shared with anywhere else. …if they get onto a registered drug use… nobody can prescribe them specific medications….all they see is that their name's been put on to some register somewhere, you know, and that everybody else is against them after that…it's usually they're self-medicating for some significant reason … they talk about these things .... then you realise that they've been abused …shame and secrets…and fear about what happens with that information once it's shared."*

7.2.2 System issues

7.2.2.1 Perspectives of the women participants

Whilst the women were aware of the need of trying to maintain a healthy lifestyle, their suggestions for improvement of services predominately related to their more immediate needs of personal safety, secure housing, financial security, accessible and affordable health care, access to understanding and non-judgmental staff and female-specific health professionals including

psychological counselling. There were also several suggestions from women participants for women only drop-in and overnight shelters, where they could access female counsellors, nurses and doctors. "W*e need more services that are designed for women that are women there… women counsellors… women doctors … you know…so they feel safe."* Another suggested a providing a mental health service where women can consult female doctors.

In addition to the lack of accommodation (especially female-only) in Perth for older women experiencing homelessness, they also stressed the importance of raising awareness of existing homelessness and health services, telling of how unaware they were of accommodation services for older women and how they needed to find a place *"females need to know there is help out there no matter what problem."*

In order to be able to find out what services might be available for them, women needed access to information technology, and many used their mobile phones, including apps, to find out about services. Although most of the participants living in transitional accommodation and in short term accommodation had their own mobile phones, those women sleeping rough spoke of how they continually had their phones stolen.

Another woman suggested there needed to be a quiet place for older homeless women to sleep and also to store their medication, *"Somewhere to make them more comfortable, because when you get old you get a bit grumpy… I'm not saying for myself, but they don't want to be around young women screaming and shouting."* Two women suggested that providing storage places for women who still had a few possessions they wanted to keep. One woman who was living in transitional accommodation spoke of how she had kept some of her belongings in rental storage premises which was expensive, but she wanted to keep what special items and memories she could until she found a more permanent place to live.

7.2.2.2 SHSP perspectives

Providers overwhelmingly supported the need for specific women's accommodation (emergency and long-term), given the women's experience of

trauma and abuse, including social and health support. Other suggestions covered a range of issues, including addressing the current competitive funding model for SHSP's and the need for a level of cohesion of homelessness and health services.

There were suggestions for an individualised approach for women and the need for health providers to understand the linkages between mental health and AOD. A SHSP manager suggested that there was a need for *"greater awareness of the hidden population" of older homeless women"*. SHSPs suggested that GPs and outreach teams could play a role in the early identification of vulnerable women at risk of homelessness, and early intervention before women end up on the streets.

SHSP staff agreed that more needs to be done to raise women's awareness of services, including health services…. *"They don't know where to go … they don't know about the services"* and that the women feel like they're in a *"vacuum"*, have lost contact with previous providers and often all their ID documentation. Many women need to leave their own residential area and it is important that they are readily able to access a range of services relevant to their needs, including available local health services for women.

There was a suggestion for provision of showers in suburban areas of need that could be accessed by homeless women, and that possibly the showers could be in a van, possibly like the one in Rockingham provided by the Salvation Army.

There was a suggestion for something along the lines of a small inbuilt community where there is a communal dining area, where women would have their own bedsits and kitchens but are housed separately, and where they've got a sense of safety and access to public transport and where they could be empowered enough to support each other as part of a community development process. The suggestion was for the government were to invest in universal innovatively designed buildings for community living, such as in some overseas countries. *"Home is a basic human right that is fundamental to health … you sleep properly, you cook your meals, you're less prone to disease."*

7.2.2.3 Healthcare providers' perspectives

Health providers recommended that providing safe accommodation as fundamental to women's health needs, including specific services to support

women who have experienced trauma and abuse. A medical practitioner said there is a need for emergency housing, especially for older women who may not have recently experienced domestic violence, noting there is considerably more supported accommodation for men in both Fremantle and Perth CBD, whilst accommodation with support services for women is limited.

Providers also stressed the need for female provided health services that could possibly work in partnership with existing primary care providers, incorporating allied health, Aboriginal liaison officers and dental services. Providers also recommended that psychiatry and psychology providers could work as part of the primary health service, given the high proportion of clients experiencing mental health problems. There was also a suggestion for a respite centre for people who are too sick for the streets but not sick enough for the hospital.

There was a strong recommendation that other health providers need to better understand the inter-relationship of homelessness and health. This includes the impact of premature ageing and a need for better connections between the homelessness, health services and the Aged Care sector. A healthcare adviser suggested possibly residential aged care providers could be supported to free up housing for older people, to provide affordable housing.

There were suggestions for a coordinated approach for the provision of multiple, ad hoc services (all well-meaning) that are predominately providing food to people sleeping rough in the Perth metropolitan area. There is a need for consistent ongoing funding of health services to support older women experiencing homelessness to overcome the current project-based funding arrangements.

7.3 Summary of key findings

This chapter has endeavoured to explain the complexity of women's experience of homelessness and how this has impacted on their health needs. The chapter has also provided the women and providers' perspectives of the barriers encountered by women accessing both social and health services. Women and providers have highlighted the need for communication and collaboration between services, for specific services and programs for older homeless women, including female provided services, culturally appropriate

services and the need for staff awareness and understanding. Women and providers have also made suggestions for ways of improving the health outcomes of older women including addressing the barriers and systemic problems.

The findings from this and the previous chapter (Chapter 6) were used to develop a set of priority actions and strategies to address the issues raised here for the consideration of a Delphi Panel as discussed in the next chapter.

Chapter 8
Delphi Panel Results

The purpose of this phase (Phase 3) of the research was to develop a set of priority actions based on the synthesis of the findings from previous phases of the study information collated during the course of the study, to seek expert opinion on their appropriateness and to prioritise them to address the healthcare needs of older women experiencing homelessness.

8.1 Delphi review process

While more general descriptions of the Delphi processed used in this study can be found in Sections 3.5.1, 3.5.2 and 3.5.3, much of the steps used in this phase of the study were not apparent until the completion of the analysis of the survey and interview responses outlined in Chapters 5, 6 and 7. Hence further details about the various aspects of preparing and undertaking the Delphi process are outlined below before describing the outcomes from the Delphi process.

8.1.1 Identification of priority actions and recommendations

Drawing on the data that led to the identification of the nine major themes and other feedback that highlighted related functional and systemic issues, potential strategies or actions were developed as recommendations to be considered by the Delphi Panel as outlined below. These were developed based on information surrounding each of the major themes identified in the previous chapter and shaped by other relevant information provided during the interview process.

Given the complex inter-relationship between health and homelessness, some of the recommended actions or strategies developed within one theme were also pertinent within another theme. A summary of the information applicable to the nine key themes, the additional factors and led to the priority actions and recommendations are shown below.

8.1.1.1 Theme 1: Accommodation and safety

8.1.1.1.1 Survey data

The majority of women (73%) were living in short term/ transitional housing at the time of survey, but prior to this had lived in a range of places including 23% who had no shelter nor accommodation (living on the streets), 9% had slept in cars and 9% had stayed in crisis (mixed sex) accommodation. Many of the women (36%) were experiencing homelessness for the first time and had been homeless for less than one year, whilst 64% had been homeless between 1-10 years. Over half the women (59%) had been victims of violence or aggression during the time they had been homeless.

8.1.1.1.2 Interview data

All the women reported that their health had been and remained affected by their experience of homelessness, and that being accommodated and feeling safe were the most important factors underpinning their health. They also expressed that they were initially unaware of how to locate housing and support services when they first became homeless which greatly added to their stress. Both SHSP and healthcare providers also reported that lack of safe accommodation acutely affected the women's health and placed the women in a precarious position and at risk of violence. They mentioned that healthcare providers play a particularly valuable role in the early identification and early intervention, before women end up on the streets. This meant that healthcare providers needed to be fully informed of the availability of homeless services so they could help the women access these services as soon as possible.

Other considerations gained during the interviews that impacted on the recommendations included the need for better communication and collaboration between health and homelessness services and to better share information about available services with the view that early identification of vulnerable women who are experiencing homelessness or at risk of homelessness could be referred to appropriate services before their situation becomes critical.

8.1.1.1.3 Recommendations

- Priority access to safe accommodation be provided to older women experiencing homelessness to meet their immediate and ongoing health needs.
- Strategies be developed to raise awareness of services provided to support the homeless, especially those for older women.

8.1.1.2 Theme 2: Women's experience of trauma and abuse.

8.1.1.2.1 Survey data

Women's past experience of violence and trauma was significant with 81% experiencing family violence, including physical and emotional abuse. 86% of women reported having injuries and trauma as their most common health concerns with 18% women still having residual Acquired Brain Injury (ABI) from physical assault by their former male partners. Many women reported that family violence directly contributed to their mental and physical health.

8.1.1.2.2 Interview data

Most of the interviewed women reported experiencing some form of family violence which they said had affected, and continued to affect, their mental and physical health. Women who had experienced abuse from their male partners reported being afraid or reluctant to see male providers and sought female healthcare providers including doctors, nurses, allied health and psychologists. Not having access to a female provider was seen as a barrier to healthcare. Providers said that trauma and abuse were common underlying and continuing health issues for women, and that the length of the time and the extent of the trauma had a significant impact on the woman's health. Additionally, healthcare providers suggested there was a need for more of their colleagues to better understand the impact of trauma and that there was a need for trauma informed services for women experiencing homelessness.

8.1.1.2.3 Recommendations

- Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established.

  These special care services included psychological counselling and healthcare services that could manage the older women's complex and overlapping mental and physical health needs.

8.1.1.3 Theme 3: Impact on a woman's health due to her inability to fulfil her role as family nurturer

8.1.1.3.1 Survey data

The women's relationship with their children and their families had a significant impact on their health. Over half of the women interviewed had regained their relationship with their children and 32% were 'close to' their family through the assistance of homelessness and community services. Connection with family was particularly important to the Aboriginal women (32% of the total women interviewed), most of whom said they were in contact with their extended families.

8.1.1.3.2 Interview data

Women said their relationship with their children was crucial to their health and many had become estranged from families due to the homelessness experience. Providers reported that homelessness creates a disconnection and loss of family is a major painful issue for these women and often these women were too embarrassed to ask their families for assistance and hid their homelessness and health needs from their families. There was a suggestion that some healthcare providers needed to better understand that women's need to re-connect and maintain their relationship with their children and family had a significant impact on their health.

8.1.1.3.3 Recommendations

- Educational opportunities be created to raise the understanding of healthcare providers of the complexity of women's need to re-connect and maintain their relationship with their children and family.
- The emotional needs of homeless women should not be neglected when planning for appropriate healthcare services including feelings of shame, embarrassment, loss of role as a family nurturer, grief and estrangement from family.

The second recommendation also addressed issues highlighted in Theme 6 (Complex interaction of physical and mental needs) as it was felt that healthcare providers needed to understand the complex impact of older women's personal feelings of shame and embarrassment of being homeless, as well as the impact of family breakdown on their health.

8.1.1.4 Theme 4: Financial Security

8.1.1.4.1 Interview data

Feeling financially secure and having access to financial support was crucial to all the women. Having to apply for Centrelink benefits was a major source of stress. Providers noted the extreme stress caused due to financial difficulties, with many of the women never having had to seek financial support before. The providers also commentated that financial insecurity affected the women's mental and physical health, and was an important consideration when planning healthcare for older homeless women

8.1.1.4.2 Recommendation

- Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation.

This recommendation was also identified in Theme 9 (Need for ongoing psychosocial and healthcare support once housed) where it was recognised that

that the health impact of the women's financial insecurity and their ongoing need for psychosocial support continued after they were provided accommodation.

8.1.1.5 Theme 5: Mental Health

8.1.1.5.1 Survey data

Approximately half the women indicated they had mental health concerns, with almost three quarters saying they had suffered from or were currently experiencing depression. Sleeping problems and fatigue were experienced by 73% women.

8.1.1.5.2 Interview data

Many of the women reported experiencing major mental health concerns from the outset of their homelessness that deteriorated further as they spiralled into worsening circumstances. They described numerous barriers to accessing mental health services including stigma, and trust issues because of their previous bad experience with mental health service, financial limitations and systemic barriers. The lack of a female health provider was identified as barrier, especially female psychologists and psychiatrists. Providers considered mental illness to be a major health need for older women experiencing homelessness. Several providers suggested this may be related to the chronic trauma and/or from domestic violence they experienced.

To address some of the systemic barriers to healthcare, providers considered that female provided health services work in partnership with existing primary healthcare providers that Psychiatry and Psychology could also work as part of the primary health service, given the high proportion of homeless clients experiencing mental health problems (seen by primary health).

8.1.1.5.3 Recommendations

- Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established.

- Primary healthcare services supporting older homeless women should be integrated with mental and allied healthcare, including priority referrals to dental care.

The first of these recommendations was also an outcome from Theme 2 (Women's experience of trauma and abuse) as it recognised the impact of trauma on mental health.

The second recommendation was tied into Theme 7 (Costs of healthcare services) and reflected the women's need for affordable and accessible allied health and dental services.

8.1.1.6 Theme 6: Complex interaction of physical and mental health needs

8.1.1.6.1 Survey data

The majority women (91%) reported having a complex mix of both mental health and physical health needs with one woman saying she had extreme injuries (ABI) from a beating. For 86% women, their most common health need related to injury and trauma, 73% experienced depression, 50% women had ongoing mental health concerns, 73% were suffering from fatigue and exhaustion.

8.1.1.6.2 Interview data

During the interview, most women confided that they had major mental health concerns aggravated by multiple physical health conditions including exhaustion, insomnia and pain. Providers reported that the women needed significant support to manage their complex health needs, and the multiple, chronic and co-existing health issues were exacerbated their homelessness situation.

They also stated that women tended to neglect their health needs and often presented late to the acute health system, and that those women who had recently become homeless presented in better health than those who had been homeless for a longer period. Those sleeping rough were in the worst health of women experiencing homelessness. Healthcare providers had found that the sooner the women were housed, the less there was a longer-term health negative

health impact, and that health providers can play a valuable role in early identification and intervention before the women's health further deteriorates.

8.1.1.6.3 Recommendations

- Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established.
- Educational opportunities be created to educate healthcare providers of the importance of early identification of older women experiencing homelessness to facilitate early intervention in terms of housing and healthcare.
- The emotional needs of homeless women should not be neglected when planning for appropriate healthcare services including feelings of shame, embarrassment, loss of role as a family nurturer, grief and estrangement from family.

The second recommendation also came out for Theme 3 (Women's role as family nurturer) as it focused on the health impact of family breakdown and women's loss of their connection with children.

8.1.1.7 Theme 7: Costs of healthcare services and pharmaceuticals

8.1.1.7.1 Survey data

For 76% women, their most common health services utilised since becoming homeless was a GP/doctor. This included 32% women identifying they had utilised a mobile GP/ Street Doctor. 55% women had utilised psychological counselling where available. Many reported a range of ongoing health issues that were unresolved. For example, 73% reported having dental problems and 82% had conditions of the ears, eyes, nose and throat. These conditions included hearing difficulties, ear infections, tinnitus & vertigo (from physical assault), poor vision and/or inadequate spectacles.

8.1.1.7.2 Interview data

Lack of bulk billing GPs, medical specialists and allied health services was raised constantly by the women. Allied health services were generally cost prohibitive

except in a few cases where they were able to access some level of financial support or a free service. Similarly, access to non-Medicare funded healthcare such as dental and psychology services were unaffordable for most. Many women also reported that the cost of medications was an issue, especially when prescribed numerous medications. Providers agreed that costs associated with healthcare was a barrier for the women. Optical, dentistry and podiatry services were believed to be “virtually non-existent” for inner city homeless people. While some homeless support services provide some healthcare services on-site, this was limited due to the costs and the inadequacy of available funding to ensure that existing programs remain sustainable.

8.1.1.7.3 Recommendations

- Primary healthcare services supporting older homeless women should be integrated with mental and allied healthcare, including priority referrals to dental care.
- Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation.

The first recommendation also linked to Theme 5 (Mental health) which addressed women’s mental health needs, including their need to access services.

The second recommendation is also linked to both Theme 4 (Financial security), which addressed women’s distress associated with their financial insecurity, and Theme 9 (Need for ongoing need for psychosocial and healthcare support once housed).

8.1.1.8 Theme 8: Stigma, shame, embarrassment and the fear of being judged

8.1.1.8.1 Interview data

The women reported often being embarrassed, ashamed and afraid of being judged when seeking health care. Many of the women found medical and nursing staff to be judgemental and disrespectful although others reported a much more positive experience. The women were especially embarrassed and ashamed to

discuss mental health issues with the GP. Similarly, providers cited that a lack of staff understanding, along with poor communication, created barriers to healthcare for older women, especially those with mental health issues. They also felt that shame and stigma of homelessness prevented the women from seeking health care. Healthcare providers had observed that the stigma of being homeless can impact on some GPs' perceptions of the women.

8.1.1.8.2 Recommendations

- The emotional needs of homeless women should not be neglected when planning for appropriate healthcare services including feelings of shame, embarrassment, loss of role as a family nurturer, grief and estrangement from family.
- Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established.

The second recommendation is linked with Theme 2 (Women's experience of trauma and abuse) and Theme 6 (Complex interaction of physical and mental health needs), recognising the inter-relationship and overlapping nature of trauma and mental health, which led to proposing the same recommendation for both themes.

8.1.1.9 Theme 9: Need for ongoing psychosocial and healthcare support once housed

8.1.1.9.1 Survey data

Women's homelessness status ranged from >3 months to <10 years, with 36% women experiencing homelessness for 1 – 5 years. Overall, 59% women interviewed said their current health had not changed over the past 12 months, and no women experiencing homelessness for up to 12 months felt their health had improved over the past 12 months.

8.1.1.9.2 Interview data

All interviewees strongly expressed the women's need for ongoing health and psychosocial support. The women spoke of how staff at the homelessness services had helped and were continuing to help them access social security, healthcare and more permanent accommodation. Homeless service providers expressed the importance of continuing to support women once they have found accommodation due to the women's need for ongoing assistance and counselling. They indicated that the older women remained vulnerable for some time after being housed as factors that contributed to their homelessness tended re-emerge, and that psychosocial and healthcare support needs should continue to be provided after women have accessed accommodation. Providers stressed the need for consistent funding of services to address the women's immediate needs and continue to address their ongoing needs.

8.1.1.9.3 Recommendation

- Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation.

This recommendation is linked with Theme 4 (Financial security) and Theme 7 (Costs of healthcare services), both of which highlight the need for ongoing support to access psychosocial and healthcare services.

8.1.1.10 Final list of recommended strategies/actions for the Delphi process

Thus, the final list of recommended actions and strategies to be presented to the Expert Panel to assess their importance using a modified Delphi process was:

1. Priority access to safe accommodation be provided to older women experiencing homelessness to meet their immediate and ongoing health needs.
2. Strategies be developed to raise awareness of services provided to support the homeless, especially those for older women.

3. Educational opportunities be created to raise the understanding of healthcare providers of the complexity of women's need to re-connect and maintain their relationship with their children and family.
4. Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation.
5. Due to the high level of physical, psychological and sexual abuse experienced by many homeless women, healthcare services should provide an option to access to female GPs, nurses, allied health and psychological service staff.
6. Primary healthcare services supporting older homeless women should be integrated with mental and allied healthcare, including priority referrals to dental care.
7. Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established.
8. Educational opportunities be created to educate healthcare providers of the importance of early identification of older women experiencing homelessness to facilitate early intervention in terms of housing and healthcare.
9. The emotional needs of homeless women should not be neglected when planning for appropriate healthcare services including feelings of shame, embarrassment, loss of role as a family nurturer, grief and estrangement from family.

To ensure the final recommended actions spanned the major themes and the broader categories identified in Chapter 6, they were mapped as shown in Table 8.1 to ensure they also incorporated the broader categories of contextual, healthcare and barriers to access.

Table 8.1 Mapping of recommendations across the themes and broad categories

Themes	Contextual issue	Healthcare needs	Barriers to access	Recommendation
Accommodation & Safety	✓			**1**
Women's experience of trauma & abuse	✓			**5**
Impact on a woman's health due to her inability to fulfil her role as family nurturer	✓			**3**
Financial security	✓			**4, 7**
Mental Health		✓		**3**
Complex interaction of physical and mental health needs		✓		**4, 6**
Cost of healthcare services and pharmaceutical			✓	**7**
Stigma shame embarrassment and fear of being judged			✓	**7, 9**
Need for ongoing support (including psychosocial and healthcare support) once housed			✓	**7**
Recommendation	**1,8,9**	**2,3,6**	**4,5,7,9**	

8.1.2 Survey questions

The Delphi survey consisted of five questions of which the first sought information on the background of the Panel member (as the information collected was anonymous), whilst the four pertained to the recommended actions.

The Panel were asked a series of questions that were designed to confirm the validity of the suggested actions based on the themes that evolved from the study, identify any gaps and recommend a priority for implementation.

Question 1 Please indicate which category is most relevant to you a) Work in a homeless organisation what provides support to people experiencing homelessness; b) Healthcare provider; c) have been or currently an older woman experiencing homelessness; d) Other (to be specified).

Question 2 Please identify (rank) your top four priorities in order of importance to address the healthcare needs of older women experiencing homelessness.

Question 3 Please provide a brief explanation regarding your choice for Priority #1

Question 4 Based in the information collected in this study, and on your own knowledge and experience in homelessness, is there another recommendation that you would suggest this is not listed above? If yes, please provide a brief explanation.

Question 5 Do you have any further comments you wish to make about the themes or recommendations from this study?

8.2 Delphi Panel results

8.2.1 Panel stakeholder categories

Q1 What stakeholder category are you from?"

Overall, 17 of the 22 invitees (77%) participated in the survey. The majority (47%) of respondents classified themselves as 'working in an organisation that provides support to people experiencing homelessness' including one women's refuge. The healthcare providers consisted of medical, nursing and allied health professionals (29%). Of particular note, two respondents were women who been homeless and were now working as advocates (12%). The two "Other" (12%) comprised two academic researchers.

Table 8.2 Stakeholder Panel respondents

Category	Invited	Participated	% Participated	% Representation on Panel
SHSP	9	8	89%	47%
Healthcare	7	5	71%	29%
Homeless	2	2	100%	12%
Other*	4	2	50%	12%
Total	**22**	**17**	**77%**	**100%**

* Local and interstate/ national researchers/ advocates specialising in older women's homelessness and homeless healthcare (Research & Advocacy)

8.2.2 Panel's top four recommendations

Q2 Please select your top four priorities to address the healthcare needs of older women experiencing homelessness.

As shown in Table 8.3, of the nine recommended actions/strategies presented to the Expert Panel, all but one received a vote as been in the "top four priorities". This was Recommendation 3 (Educational opportunities be created to raise the understanding of healthcare providers of the complexity of women's need to re-connect and maintain their relationship with their children and family).

The recommendations receiving the largest number of votes were:

- Recommendation 1 (Priority access to safe accommodation be provided to older women experiencing homelessness to meet their immediate and ongoing health needs) with support from 16 members of the Panel (94%) consisting of the experts from all of the stakeholder categories.
- Recommendation 4 (Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation, 82%),
- Recommendation 7 (Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established, 53%) and finally
- Recommendation 2 (Strategies be developed to raise awareness of services provided to support the homeless, especially those for older women).

Recommendation 5 (Due to the high level of physical, psychological and sexual abuse experienced by many homeless women, healthcare services should provide an option to access to female GPs, nurses, allied health and psychological service staff) and Recommendation 9 (The emotional needs of homeless women should not be neglected when planning for appropriate healthcare services

including feelings of shame, embarrassment, loss of role as a family nurturer, grief and estrangement from family) all receiving 41% of the votes.

8.2.3 Top priority and explanations

Q3 Please provide a brief explanation regarding your choice for Priority #1.

Despite eight of the recommendations being identified as within the “top four priorities”, the Panel overwhelmingly identified Recommendation 1 (fourteen members, 82%) as their highest priority (‘Priority access to safe accommodation’; Table 8.3).

Only two Panel members chose Recommendation 4 (Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support) and one chose Recommendation 7 (Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established).

The Panel’s comments are shown in Table 8.3.

Table 8.3 Panel selection of top four priorities to address the healthcare needs of older women experiencing homelessness

Rankings of the Recommendations (Q2) and associated text for those ranked the highest (Q3)	Top 4 priority (*n*=17)	Number 1 priority (*n*=17)	Sample of Panel comments
Recommendation 1: Priority access to safe accommodation be provided to older women experiencing homelessness to meet their immediate and ongoing health needs.	16	14	*"Feeling safe is very hard when you are living on the street, there is violence everywhere, so feeling safe is a high priority"* (Woman who had experienced homelessness) *"This is often the missing piece in homelessness interventions, and we have seen from the evaluation of 50 Lives and Homeless Healthcare and the RPH HT, that supporting people to access health and psychosocial support has a huge impact on tenancy sustainment, wellbeing, capacity to contribute to community"* (Other) *"…older women potentially are more at risk on the streets than other cohorts of people. I believe that to effectively provide meaningful and lasting physical, mental, and emotional support to the cohort of older women they need to be in safe accommodation"* (SHSP) *"Without safe accommodation, the other strategies will only be a band aid to changing the lives of these women"* (HCP) *"Safe lodgings equate to improved mental health and safe storage of medicines with adequate rest"* (HCP). *"Housing provides safety and security for women to then address their health issues"* (SHSP)
Recommendation 4: Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation.	14	2	*"Just providing safe accommodation may not always be the answer as homelessness is complex, people's reasons for finding themselves in such situation are varied as are their needs. Homelessness services are equipped with resources and staff who can best understand and address these needs for the older homeless women. However, these services are often underfunded. With more sustainable funding, they can be expanded to include the psychosocial and healthcare supports that women require, so that a completed wrap around service can be offered and best outcomes achieved"* (SHSP).

Rankings of the Recommendations (Q2) and associated text for those ranked the highest (Q3)	Top 4 priority (*n*=17)	Number 1 priority (*n*=17)	Sample of Panel comments
			"Women's Health Centres are the obvious place for homeless service providers to link older homelessness women to assist in addressing women's health issues, the women's health network services are with low cost or fees are waivered. Many community women's health services have MOU's with service providers addressing the social determinants of health and wellbeing (HCP).
Recommendation 7: Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established.	9	1	*"Addressing the complex mental and physical health needs takes priority as these can be viewed as one of the primary underlying and pervasive reasons as to why older women may encounter homelessness, and remain in cycle of homelessness…(after which the other issues follow - e.g. sourcing suitable accommodation, disconnection from family and other support networks, an awareness of homelessness and associated issues / needs, linkage to appropriate services etc)."*(SHSP)
Recommendation 9: The emotional needs of homeless women should not be neglected when planning for appropriate healthcare services including feelings of shame, embarrassment, loss of role as a family nurturer, grief and estrangement from family.	7		No further comments
Recommendation 2: Strategies be developed to raise awareness of services provided to support the homeless, especially those for older women.	7		No further comments.

Rankings of the Recommendations (Q2) and associated text for those ranked the highest (Q3)	Top 4 priority (*n*=17)	Number 1 priority (*n*=17)	Sample of Panel comments
Recommendation 5: Due to the high level of physical, psychological and sexual abuse experienced by many homeless women, healthcare services should provide an option to access to female GPs, nurses, allied health and psychological service staff.	7		No further comments
Recommendation 8: Educational opportunities be created to educate healthcare providers of the importance of early identification of older women experiencing homelessness to facilitate early intervention in terms of housing and healthcare.	6		No further comments
Recommendation 6: Primary healthcare services supporting older homeless women should be integrated with mental and allied healthcare, including priority referrals to dental care.	5		No further comments
Recommendation 3: Educational opportunities be created to raise the understanding of healthcare providers of the complexity of women's need to re-connect and maintain their relationship with their children and family.			No further comments

8.2.4 Other Panel recommendations

Q4 Based in the information collected in this study, and on your own knowledge and experience in homelessness, is there another recommendation that you would suggest this is not listed above? If yes, please provide a brief explanation.

As shown in Table 8.3, the Panel made a number of suggestions in response to this question including changes to two of the existing recommendations.

One Panel member suggested reframing Recommendation 2 (Strategies be developed to raise awareness of services provided to support the homeless, especially those for older women) to create specific services for older homeless women.

Two others suggested extending Recommendation 4 (Provision of funding to enable homelessness services to provide or refer clients (older women) to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation) to include women at risk of homelessness and to provision of adequate psychosocial and health support for women once housed by adequately funding existing services to provide this support.

Other potential recommendations included:

- The need for longer-term housing solutions;
- Awareness raising for community and providers of women at risk of and experiencing homelessness; and
- Interagency communication, collaboration and coordination.

Several other suggestions highlighted the need for:

- Non-judgmental services and trauma informed practices;
- Access to legal and peer support;
- Multidisciplinary women specific services;
- Culturally appropriate accommodation and healthcare services for older Aboriginal and CALD women;

- A strategy to re-build family relationships after family breakdown during the homelessness experience;
- Appropriate level of funding to provide a coordinated and sustainable approach to provision of support to homelessness services, including healthcare for homeless women;
- Underpinning policy development and service delivery for older women using the social determinants of health as the policy framework; and
- Involving women with the lived experience of homelessness in policy making, service planning and delivery.

A sample of the Panel's comments that underpin the series of dot points above is shown below.

Comments pertaining to longer term housing:

> *"I am concerned accommodation is temporary. Housing, permanent housing, with support attached (if needed) is the priority"* (Other)
>
> *"Having services that are more sustainable for women, they should have more of a long term approach, not just one year of transitional assistance. It takes more than a year to recover from being homeless. I felt that the rug had been pulled out from under my feet again and I was alone again in trying to get back on my feet"* (Woman who had experienced homelessness)

Awareness raising:

> *"Awareness raising needs to be both for service providers and for homeless women as well as women at risk of homelessness e.g. women in DV. I think some general community awareness raising would also be helpful as friends and family members may not think to ask about homelessness or suspect problems but don't know how to bring the subject up. I think it could be framed in a similar way to how community awareness has been raised around suicide risk"* (SHSP)

Interagency communication, collaboration and communication:

> *"Better coordinated care for women at the point of where they engage in the system -rather than women having to tell their stories over and over again to multiple providers; early intervention- we know that women*

under report so to be able to develop integrated models that intervene before women enter the crisis space needs to be a priority" (SHSP)

"Just providing safe accommodation may not always be the answer as homelessness is complex, people's reasons for finding themselves in such situation are varied as are their needs. Homelessness services are equipped with resources and staff who can best understand and address these needs for the older homeless women. However, these services are often underfunded. With more sustainable funding, they can be expanded to include the psychosocial and healthcare supports that women require, so that a completed wrap around service can be offered and best outcomes achieved" (HCP)

Appropriate funding to provide a coordinated and sustainable approach:

"I think having a more sustainable approach to homeless would be a lot better than what we currently have" (Woman who had experienced homelessness)

More sustainable funding for existing services that already address the healthcare needs of homeless women in the community services setting as the future of many of these services is in jeopardy" (SHSP)

Rebuilding family relationships:

"I would have a fifth priority of rebuilding family relationships as I also feel that it is important to rebuild the family relationships that break down when a person becomes homeless" (Woman who had experienced homelessness)

Multidisciplinary women specific services:

"The inclusion of women's health services, as they have a gendered specialist approach to addressing issues such as family domestic violence and sexual assault. They are trauma informed and have female only staff - psychologist, GP, counsellors and partnerships with other allied health practitioners" (HCP)

Non-judgemental and trauma informed practice:

"I think increasingly it is important that all services (health and homelessness) have an explicit commitment to trauma informed practice" (Woman who had experienced homelessness)

Culturally appropriate services:

> *There needs to be a cultural aspect included in healthcare and accommodation. Older Aboriginal women and CALD women can have specific needs and specific accommodation needs"* (SHSP)

Underpin policy development and service deliver using the social determinants of health:

> *"Our lives are complex as is health. The social determinants of health include (housing, money, transport, food security as well as health. I would recommend that the health needs of older women experiencing and at risk of homelessness be seen in the broader context of their lives. I recommend that safe and secure housing be seen as a critical health issue for older women and that efforts be made to increase women's ability to access such housing for the rest of their lives"* (Woman who had experienced homelessness)

Involve women with lived experience of homelessness in service policy, planning and delivery:

> *"Need a recommendation around involvement of women with lived experience of homelessness 'nothing for us without us'" (Other)*
>
> *"Recommend that older women themselves be included in policy making and delivery of services"* (Woman who had experienced homelessness)

8.2.5 Further comments and suggestions from Panel

Q.5: Do you have any further comments you wish to make about the themes or recommendations from this study?

The Panel provided several further comments and suggestions relating to the themes and recommendations. Most of the Panel's comments related to service delivery including the need for a sustainable approach and structural and creative solutions. The Panel reiterated the need for a gendered and Social Determinant approach in homelessness and health service delivery, including the need to involve older women who have experienced homelessness in policy and service planning. One SHSP Panel member had observed an increasing

number of older homeless women who had endured long term trauma and elder abuse presenting for counselling.

A sample of the Panel's comments is shown below:

> *"I note there is limited account of structural solutions or interventions"* (Other)
>
> *"This is extremely important research identifying the health impacts on women of being homeless or at risk of homelessness and will strongly add to a better understanding of the need for specialist approaches to housing and services for older women. I really look forward to its completion!"* (SHSP)
>
> *"I think your research focus is essential and will add another layer to the very small research being done for and with older women experiencing or at risk of homelessness. I believe there is a need to take a broad view of the complexity of our lives and see gender, ageing, housing, health, employment and enterprise as intertwined issues that cannot be resolved separately"* (Woman who had experienced homelessness)
>
> *"Important to have a gendered approach recognising older women's homelessness is a systemic policy issue which needs to be addressed….you have nailed the research with the 9 themes, there is a clear gendered perspective which is most notable is theme 3, however also evidenced in themes 1,2 & 3"* (HCP)
>
> *"Abuse of the elderly is on the increase and our service is dealing more and more with homeless elderly women that have endured years of trauma"* (SHSP)

There was high agreement among the Expert Panel on support of the research findings and the proposed recommendations.

A discussion of the research findings including the key recommendations from the Panel and the final study recommendations, in relation to the literature and the implications for policy formulation and service delivery, will form the basis of this final chapter.

Chapter 9

Discussion, Conclusions and Recommendations

As stated in the introduction, this study sought to investigate the personal life circumstances of older homeless women who live in the Perth metropolitan area and their healthcare needs through four specific research questions:

1. What are the living arrangements, self-reported health conditions and healthcare services utilised by the women?
2. What do the women see as their primary/ predominate healthcare needs?
3. What factors influence the women's ability to access healthcare services to improve their health?
4. What actions could be undertaken to help improve the health and wellbeing of older homeless women?

A summary of the key findings of the study that relate to these questions are provided in sections 9.1.1 – 9.1.2 (Research Question 1), sections 9.1.3 – 9.1.4 (Research Question 2), sections 9.1.5 – 9.1.6 (Research Question 3) and Section 9.1.7 (Research Question 4).

The information required to address the research questions was obtained through a series of surveys and face-to-face interviews with older homeless women from across the metropolitan area. The development of the interview questions was informed by a social determinants of health framework to ensure a broad systems approach to exploring the women's homelessness, their health needs and the challenges they faced accessing health services. The criteria outlining the methodology, rigour in qualitative studies is evaluated through the criteria of credibility, dependability, confirmability, transferability and authenticity (Colarafi & Evans, 216; Cope, 2014). These criteria were achieved as planned and outlined on page 49 section 3.4.10.3

A unique feature of this study was that it explored the issues discussed with the women in conjunction with people working in both the specialist homeless support and healthcare services for their insights and perspectives. This

approach validated many of the views expressed by the women, but also provided some additional insights that came from the wider experience of the specialist support and healthcare staff within the context of older homeless women. For example, the SHSP and HCP interviewed agreed with the women's view that accommodation as paramount for their clients to address the stress, anxiety, mental and physical health and that the stress of homelessness exacerbated and compounded mental their health needs. Healthcare providers were able to expand on this by highlighting that those sleeping rough often presented to ED quite ill and exhausted; noting that while alcohol was used by many of the women as a coping strategy, illicit drug use was generally not considered to be a major problem.

This method of cross validating the issues was particularly useful in understanding barriers to accessing services and exploring alternative care pathways. For example, the SHSPs highlighted the importance of their service in helping the homeless re-establish their personal identification documentation so they could access social and health services while healthcare professions described the women's reluctance to admit to their being homeless and experiencing mental health issues.

Another important component of the study was to seek the input of a Delphi Panel comprised of representation from women with the lived experience of homelessness, specialist homelessness service and health providers who had worked extensively with older homeless women and local and national researchers/ advocates specialising in older women's homelessness and homeless healthcare. Their feedback and suggestions were considered in determining of the study's recommendations.

This concluding chapter draws together the major findings from this study with reference to other work in the published literature before making recommendations to improve existing services and further research in this field. The chapter will highlight the major findings to incorporate the predisposing factors contributing to the women becoming homeless, their health needs including their need for housing and specialised services and factors affecting access to health services.

9.1 Major findings

9.1.1 Predisposing factors for homelessness amongst older women

The underlying theoretical approach used by this study drew from the work of Gelberg, Andersen, & Leake (2000); Aday & Andersen (1981); Kertesz et al. (2013 & 2014) to evaluate homeless people's health needs and health service utilisation and to incorporate the fundamental principles of the World Health Organisation Social Determinants of Health (Marmot, 2005; Marmot & Allen, 2014, WHO, 2008; McLoughlin & Carey, 2013) resulting in a series of questions that explored some of the predisposing factors contributing to the women becoming homeless.

Through the individual stories recounted by the 22 women at the time of interview, it was apparent that many of the women had experienced multiple episodes of homelessness. However, for almost a third, it was their first episode of homelessness, although in some cases, this single episode had lasted for multiple years. This diversity in the homelessness experience in older homeless women was also observed by Petersen & Parsell (2014) who reported that older homeless Australian women were not a homogenous group as their life experiences and pathways into homelessness varied (Petersen & Parsell, 2014; Phipps et al., 2019).

The current study also found that a range of social and economic factors underpinned their homeless situation that included family breakdown, history of trauma and abuse, and financial insecurity. This is in agreement with numerous other studies that have also reported a range of adverse experiences and inter-related factors such as family crises, abuse, trauma, mental health, lower socioeconomic status, living alone and lack of access to safe housing contribute to older women becoming homeless (Fitzpatrick et al., 2013; Darab & Hartman, 2013; Petersen & Parsell, 2014; Sharam, 2015; Bowpitt et al., 2011; Phipps et al., 2019).

Likewise, the background of the women in the current study reflected the three pathways identified by Petersen for older Australian women to fall into homelessness consisting of (i) from a conventional housing history, (ii) living with ongoing housing disruption and (iii) living transient lives (Petersen & Jones, 2013;

Petersen et al., 2014). However, the women's stories also reflected Fitzpatrick's work that identified the pathway to homelessness culminating from a range of adverse life events and compounding situational crises (Fitzpatrick et al., 2013), and that of Burns who noted progressing down these pathways could be either gradual or rapid progression (Burns & Sussman, 2019). These observations suggest that there are a series of interconnected pathways that consist of a series of compounding events that can result in a gradual or rapid loss of housing certainty for older homeless women. The fact that the current study included women whose personal stories illustrated journeys that aligned to the described pathways suggests it captured a good cross section of the older female homeless population from which to draw some broad conclusions.

9.1.2 Health needs

In keeping with much of the literature on the health status and needs of the homeless community, about 70% of the women in this study reported their current health as fair to very poor. While some indicated that their health had improved since finding somewhere safe and secure to live, most reported their health was similar to 12 months prior.

The women mentioned a wide range of health issues with almost all reporting injury and trauma (86%), conditions of the ears, eyes, nose and throat (82%) and chronic pain (60%). While many also reported living with chronic health conditions such as arthritis, osteoporosis, diabetes and heart disease, others were trying to cope with complex conditions such as Lupus Erythematosus, liver disease, HIV, cancer and chronic mental health issues. While this study could not ascertain whether these diseases were more prevalent in the homeless women than the general population, others have found the homeless have higher prevalence of a range of physical and mental conditions that result in high rates of morbidity and multi-morbidity (Story, 2013; Chant et al., 2014; Brett et al 2014; Phipps et al., 2019), and mortality (Aldridge, 2019). In addition to having a greater disease burden in the homeless, it has been found that people with a history of homelessness also have a higher rate of onset of diseases such as chronic disease and other age-related conditions (Fazel et al., 2014).

The interviews with the women, and the specialist homeless and healthcare providers, highlighted the fact that mental and physical health conditions were exacerbated by age and lack of a stable accommodation. For many, their mental health condition was both a predisposing factor and an outcome of their homelessness, which added complexity to their healthcare and support needs. Other researchers in this field have found that the stress of homelessness can have a long term effect on older women's physical and mental health (Waldbrook, 2013) and that those with pre-existing mental illness suffer additional emotional distress, long-standing loneliness and social avoidance making them more socially isolated and vulnerable to depression (Bonugli et al., 2013) and self-blame (Padgett et al., 2006), all of which can impact on them seeking support (Klop et al., 2018).

Whilst homeless, most women in this study reported that most of their medical and healthcare needs were provided by GP services. Interestingly, this exceeded the reliance on emergency departments which other literature suggested was the most common source of healthcare for homeless people in USA (Kushel, Perry, Bangsberg, Clark, & Moss, 2002; Feldman et al., 2017), the UK (Iacobucci, 2019) and within Australia (Moore et al., 2011; Wood et al., 2017; Stafford & Wood, 2017; Brown et al., 2019). The difference in these findings may reflect the current study's focus on older homeless women, rather than the wider homeless population, and that many of the women were in at least temporary housing, which has been shown to decrease the reliance on ED and hospitalisation (Ni Cheallaigh et al., 2019). Half of the women in the current study reported being admitted into hospital with four stating the admission was related to acquired brain injuries from domestic violence. Also, in keeping with the literature (Padgett et al., 2006; Bonugli et al., 2013; David et al., 2015; Phipps et al., 2019), many of the women reported having significant mental health concerns that ranged from anxiety and insomnia, depression and more complex mental illnesses. While some women attended mental health services provided within the public healthcare system, most received their care through GP services and psychological counselling.

Notwithstanding the services described above, the current study also identified the need for a range of other health and support services such as vision, dental, sexual health, comprehensive and holistic care, managing their diet and chronic

health conditions and support with managing their medication (Salem & Ma–Pham, 2015). Women in this study who had been sleeping rough found it particularly difficult to manage their diabetes because of their inability to sustain a healthy diet and constantly having their medication stolen. A recent Australian review found a high proportion of women who were sleeping rough had high level needs for mental health and physical healthcare (Box et al., 2018).

9.1.3 Domestic and family violence

Eight two percent of women in this study (18/22) reported experiencing domestic and family violence, and of these, 83% (15/18) said the perpetrators had been intimate partners. This is in keeping with national data that shows domestic and family violence as the most common cause of homelessness for Australian women (AIHW, 2018b), although the figure in older women may be even higher as others have shown they are less likely to disclose abuse for a range of reasons including not wanting to be labelled as a victim, shame, denial including self-denial, suppressing the experience or allocating it to the past and moving on, suppression, fear of isolation, fear of estrangement from family including children and grandchildren, difficultly in leaving their lifetime home, lack of financial resources and lack of knowledge about accessing resources and services (Loxton et al., 2017b; Tually, Faulkner, Cutler & Slatter, 2009).

Research has shown that survivors of domestic violence are much more likely to experience housing insecurity and homelessness (Dichter, Wagner, Borrero, Broyles, & Montgomery, 2017), which has been comprehensively covered in a recent systematic review (Klein et al., 2019). Although being a predisposing factor of homelessness, the consequences of DV, both before and after becoming homeless, also had a significant impact on the women in the current study and made their accessing healthcare support even more complex. In this current study, four women reported having acquired brain injuries from domestic and family violence which continued to impact on their health. This is consistent with the findings from a longitudinal British study which highlighted the complex nature of women's experience of abuse, violence and homelessness impacted on their health and social care needs (Cameron et al., 2016) and the Australian Longitudinal Study of Women's Health, which also reported that intimate partner violence continues to impact on women's health outcomes over time and that

"women who had lived with intimate partner violence were more likely to report poorer mental health, physical function and general health, and higher levels of bodily pain" (Loxton et al., 2017a, p. 1). Other studies have identified that women affected by DV exhibit a range of health problems including anxiety, depression and Post Traumatic Stress Disorder (PTSD), poorer physical health and chronic pain (Loxton et al., 2017b; Robertiello, 2006; Williams & Mickelson, 2004; Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012).

9.1.4 The importance of housing

When asked about their perceived main health needs and what factors were important to them attaining good health and a sense of wellbeing, the most significant finding was that the women overwhelmingly responded that safe and secure accommodation was pivotal to their health and wellbeing. Furthermore, accommodation was seen as somewhere to relax, heal, reconnect / engage with family, store their belongings and their medications. It also removed them from the streets and sleeping rough which exposed them to ongoing physical and sexual abuse and addressed some of the women's feelings of shame of being homeless that could hinder their preparedness to access health and other care services.

Importantly, the women also recognised that not having a stable place in which to live, combined with their getting older, contributed to their physical and mental health problems. The women who had lived on the streets reported experiencing violence and sexual assault with healthcare and homelessness service providers also expressing concern that these women were extremely vulnerable to further assault. A number of studies have identified that violence is a common experience for both men and women living on the streets and that women sleeping on the streets are especially at risk of assault (Bowpitt et al., 2011; Vallesi et al., 2018; Bonugli et al., 2013; Petersen & Parsell, 2014).

The fact that the women saw housing as their primary health need fits with concepts such as Maslow's hierarchical needs that suggests homeless people address their basic safety and physiological needs (food, water, sleep, safety and security) before they try to find preventative care (Gelberg et al., 2000) or seek appropriate healthcare outside of critical circumstances (Davies & Wood, 2018; Plumb, 2000).

9.1.5 Women's experience of social exclusion

This study identified a number of factors relating to social exclusion and sense of disconnection from their families and the wider community that followed a relationship breakdown, family violence, estrangement from family and homelessness. Family breakdown is recognised as a major adverse life event contributing to homelessness (Fitzpatrick et al., 2013), and poverty, economic disadvantage and family conflict can further contribute to homelessness (McLoughlin & Carey, 2013).

In this study, women's loss of connection with their children and grandchildren during and after the time they had become homeless had impacted on their on their health and wellbeing and caused them great distress. This was also very prominent for the Aboriginal women interviewed in this study with one woman stating, *"I'm family orientated, most Aboriginal people are, because they've had a lot to do with their grannies, it's important, the grandmother's role, it's always part of you."*

The findings of the health impact of women's relationship with their children and family reflect that women's traditional role as family carer is a key social determinant of health (Department of Health and Ageing [DHA], 2010; Department of Health [DH], 2018). A qualitative study of older homeless women in New York City (Gonyea & Melekis, 2017) highlighted the importance of women's emotional bonds with family to provide both access to tangible support and affirm the women's identity, especially their roles as mothers and grandmothers. A recent Perth study also found that homeless women expressed the need to maintain connection with children (Box, Flatau, Lester, & Callis, 2018). In a very recent study, Phipps et al (2019) observed that "homeless mothers report less social supports, less contacts with family and less people they can count on when needed" (p. 6).

9.1.6 Factors affecting access to health services

While this study found that all of the homeless women had accessed healthcare for their various health needs, a number of factors influenced their ability to do so, many of which were relevant to the social determinants of health.

Notably, one of the most significant risk factors for becoming homeless is insufficient income (Zaretzky et al., 2013) and in Australia, there are increasing numbers of older women living in poverty (AHRC, 2019; Petersen & Parsell, 2014).

In the current study, the women said that their financial situation limited their ability to access services largely due to the lack of bulk-billing GPs, medical specialists, allied health (including psychological) and dental services and the ability to pay for any Medicare gap fee. The cost of medications was also a problem, especially when women had been prescribed numerous medications and were unable to cover the gap of a pensioner discount for some medications.

Concerns regarding lack of access to allied health services for the homeless, particularly physiotherapy and podiatry, have been reported by others (Wood et al., 2018). Similarly, in an evaluation of a large specialist homeless support service located in Perth, their clients expressed the importance of having access to free primary care, allied health and dental services (Personal Communication, Day Centre Clinic Manager, St Patricks Community Support Centre January 2019).

Many of the women in the current study also said the cost of transport contributed to their inability to attend GP and specialist healthcare as has been reported by a study by Davies (Davies & Wood, 2018).

In keeping with Salem and Petersen, findings from the current study also identified that, especially for those who were homeless for the first time, the women lacked knowledge of where and how to access social and healthcare services (Salem & Ma-Pham, 2015; Petersen, 2014). Perhaps more commonly however, many of the women in this study reported stigma, shame and embarrassment were common barriers to health care. The women described how they were often embarrassed, ashamed and fearful of being judged when seeking healthcare due to the “stigma around homelessness” and also the stigma associated with mental health and where some women reported they too embarrassed to tell their GP they “might have a mental health issue”. The importance of this factor in accessing support and healthcare has been noted by other researchers who found that the stigma of being homeless compounds the older women’s reluctance to seek support (Kisor and Kendal-Wilson, 2002). Homeless people’s experience with healthcare staff also varies according to their

perceptions of being treated with prejudice or being listened to (Rae & Rees, 2015; Lester & Bradley, 2001). Similarly, the challenges of lack of trust, prejudice and poor staff communication compounded by the homeless people's feelings of embarrassment and shame, and how making them feel welcomed, listened to and supported can make a profound positive difference to their health seeking behaviour and overall wellbeing (Hauff & Secor-Turner, 2014; Rae & Rees, 2015).

Similar experiences were conveyed by the specialist homeless services and healthcare providers who acknowledged that women's shame and embarrassment, compounded by a lack of staff understanding and poor communication, creates barriers to healthcare and heightened their perceptions of feeling unwelcome, judged and stereotyped. This is consistent with other studies that found that homeless people seek healthcare providers who they believe are committed to their care and who treat them with respect, sensitivity and acceptance (Kertesz et al., 2013; White & Newman; 2015; Campbell et al., 2015; Rae & Rees 2015; Davies & Wood, 2018). Further to this, healthcare staff can find it difficult to manage the mixture of inherent health and social problems which further exacerbates communication difficulties (Jego, Abcaya, Ștefan, Calvet-Montredon & Gentile, 2018).

The study also found that lack of availability of female healthcare providers affected women accessing healthcare, particularly those women who had experienced abuse from their male partners. The long term consequences of domestic and family violence also impacted on their access of healthcare with many traumatized women reporting being afraid or reluctant to see male providers and sought female healthcare providers including doctors, nurses, and psychologists. This is reflected by David et al (2015) who identified that women whose previous experience of abuse from males can feel safer with female providers to overcome their lack of trust and begin to address their complex health needs, particularly their mental health. The study found that access to female healthcare providers for counselling and screening was important for women affected by trauma and for management of sensitive reproductive issues, as well as for sexual health and cervical cancer screening and is reflected in the literature (Brooks & Phillips, 1996; Moravac, 2018; Salem et al. 2018; Wood et al., 2018). Similarly, for multicultural homeless women, access to a female

healthcare provider has been demonstrated to enhance their likelihood of accessing healthcare services (Salem & Ma-Pham, 2015).

The study also found that for women with ATSI and CALD backgrounds, lack of culturally appropriate services was a barrier for some needing to access healthcare, especially in their early stage of homelessness. This issue was highlighted by a recent paper by Martin et al. (2019) who also identified that rural and remote Aboriginal people can become stranded in the city after moving to Perth for health treatments.

9.1.7 Recommended actions to improve access to health services

As described in earlier parts of this thesis, homelessness and the distinct needs of homeless people for healthcare are complex and multifaceted. Homelessness generally does not occur as a single pathway nor look the same for every individual who finds themselves in this situation. Homeless people's pathways into homelessness can be based on a series of experiential clusters and compounding situational crises (Fitzpatrick et al., 2013). Petersen's study highlighted the need for a systemic approach to develop designated programs and service models for older women, given that they have lived diverse lives and their pathways into homelessness have varied (Petersen & Parsell, 2014). As a cross-sectional study, this study has identified many of the issues highlighted by the earlier report by Moore and others (Moore et al., 2011), with lack of accommodation, social exclusion (from family and fear of being judged by others), interactions between physical and mental health concerns and the challenges of accessing healthcare services all highlighted within the nine major themes.

The series of activities/actions developed from these themes (see 7.1.1.10) were presented for consideration by an Expert Panel that consisted of people with first-hand experience in, or providing support to, homelessness. This Panel almost unanimously (14 out of 17 persons) saw the provision of safe accommodation as the most urgent priority to be provided to older women to meet their immediate and ongoing health needs.

This is in keeping with the view of others who not only saw this as a solution for the general housing crisis for homeless people (Tsemberis, 2011) but also as

an effective way to reduce healthcare costs (Doran, Misa, & Shah, 2013; Garrett, 2012; Wood et al. 2018; Vallesi et al., 2018), and essential for homeless women to regain their lost autonomy and enable recovery (Padgett et al., 2006; Petersen & Parsell, 2014).

The Panel also recognised the need for homeless services to be funded to provide or refer their clients to psychosocial and healthcare support early in their stage of homelessness and well after they access accommodation (see 7. 2.3). This recommendation is based on the common observation of poor health in homeless people, with many reporting that it was a major factor or single most important factor contributing to their homelessness (Bottomley, 2001). The role of poor mental health in a bi-directional contribution to homelessness status has been reported both in Australia and elsewhere (Kertesz et al., 2014; Brackertz, Davison & Wilkinson, 2019; Robertson & Winkleby, 1996). In addition to contributing to the improvement in health of older homeless women (Waldbrook, 2013), supportive housing and other community services can potentially provide these women access to ongoing support to prevent them against becoming homeless again (Phipps et al., 2019) in a manner that is cost saving to government largely through reduction in health and justice services spending (Flatau & Zaretzky, 2007; Zaretzky et al., 2013; Flatau et al., 2018).

The need for these services to be provided in a safe, secure and easily accessible manner was also highlighted by the Panel for this study in recognition of the impact of trauma on the mental and physical health of the women. The need for greater understanding of the impact of trauma and its continuing effect on the health of women who have experienced trauma has been recognised by other researchers (Padgett et al., 2006; Bonugli et al., 2013; David et al., 2015; Phipps et al., 2019).

Another recommendation supported by the Panel was with regard to the fragmented approach to the provision of services. The need for better interagency communication and collaboration was conveyed and linkages between homelessness and healthcare services, as well as linkages between healthcare services. The need to address service fragmentation has been recognized by other research (Cameron et al., 2016) with more recent studies suggesting or

reporting on complex models of care designed for the homeless here in Australia (Davies & Wood, 2018), in the US (Bottomley 2001; O'Connell et al., 2010) and in the UK (Hewett & Halligan, 2010). In a recent literature review of effective primary care programs for the homeless, Jego et al. (2018) reported that most of these programs provided a multidisciplinary and integrated approach to care and many proposed co-located services between primary healthcare services, mental health services, social support and other services in varying combinations. They also reported that there was evidence that tailored services were more effective and provided more appropriate care and better client experience than standard primary healthcare. Many of these specialized services, however, suffered from being under resourced. Further, the health of the homeless cannot depend solely on the provision of primary care, but also require other efficient interventions such as case management and social support for complex mental health and drug abuse (Jego et al., 2018).

The Panel also supported the recommendation that, due to the high level of physical, psychological and sexual abuse in the women, healthcare services should provide the option to access female healthcare staff. This is in keeping with other studies that have highlighted women's preference for a female provider, particularly for women who have been traumatised (David et al., 2015). Similarly, the Panel also supported the recommendation that all healthcare providers be educated of the importance for early identification of older homeless women to facilitate early intervention in terms of housing and healthcare and an understanding of the women's need to re-connect and maintain their relationship with their children and family. The impact of family disruption and breakdown on women has been recognized by other studies (Fitzpatrick et al., 2013; Phipps et al., 2019) as has the importance of women's emotional bonds and maintaining connection with family and children (Gonyea & Melekis, 2017; Box et al., 2018).

During the course of the current study, innovative specialist homeless services were identified that act as exemplars to address many of the key recommendations made by the Expert Panel. For example, the Royal Perth Homeless Team (RPH HT) is a collaborative initiative between Royal Perth Hospital (RPH) and the Homeless Healthcare General Practice (HHC GP). This service provides the opportunity to link homeless people who have been admitted

to hospital with specialised homelessness healthcare providers and with relevant community based services throughout their hospital stay and after they have been discharged, and thus facilitates continuity of care and addressing ongoing health and psychosocial needs of people experiencing homelessness. The Homeless Team also works collaboratively with other hospital staff to help them understand needs of clients and strategies for linking to services. The RPH HT and HHC GP are part of a wider collaboration with local homelessness services through the WA *50 Lives 50 Homes* project, which uses a Housing First model to house and support Perth's most vulnerable and complex needs people who are rough sleepers (Gazey, Vallesi, Cumming & Wood, 2018). The RPH HT is modelled on the evidence-based UK Pathway model of hospital homeless healthcare developed in London in 2009 where GPs from homeless health practices are introduced into tertiary hospitals to work alongside other Pathway team members including nurses and caseworkers linked to community services to rehouse and support homeless patients and using a social determinant approach to address homelessness and health inequities (Hewett & Halligan, 2010; Hewett et al., 2012). After the first 18 months in operation, RPH HT provided support people experiencing homelessness by facilitating linkages and partnerships between acute, primary and community services to assist homeless people into housing and to remain housed, with a 35% reduction in high frequency presenters to RPH ED (Gazey et al., 2018).

This model (and similar ones) goes a long way to implementing many of the steps outlined in a recent Commentary in The Lancet Public Health that calls for specialist, integrated homeless health services that can manage long term conditions and a move from emergency to permanent housing solutions for the homeless (Aldridge, 2019).

9.2 Significance and contribution of the findings

This study combines the voices of older homeless women from across the Perth metropolitan area with staff from the special homeless support services and healthcare sector to identify the best ways to help address their healthcare needs.

Clifford, Wilson & Harris (2019) have stressed that health policy development is required to improve the health of homeless populations by addressing the

broader social determinants of health. However, this has been problematic due to a lack of understanding around the complexities of homelessness and the difficulties of linking the social determinants of health directly to health outcomes. Future policy action requires addressing systemic issues, including inter-sectoral collaboration and the genuine, collaborative involvement of people with lived and living experience of homelessness in policy design and delivery.

This study provides evidence-based research that can be translated and utilised for policy development and intervention from a health perspective. The study also validates the need to incorporate the broader social determinants of health into health system policy and planning. It also demonstrates the need to better understand the complexities around the problem of older women's homelessness, as highlighted by the following quote from a member of the Delphi Panel:

> *"I think your research focus is essential and will add another layer to the very small research being done for and with older women experiencing or at risk of homelessness. I believe there is a need to take a broad view of the complexity of our lives and see gender, ageing, housing, health, employment and enterprise as intertwined issues that cannot be resolved separately"* (Woman who had experienced homelessness).

This study extends the view that the principal need of many older homeless women is housing (NOWHHG, 2018), advocating for the provision of safe, affordable, long-term housing with wrap-around social and healthcare support services. It was found that many of the women have complex health and mental health concerns.

The importance of supportive health, housing and other community services to address underlying and ongoing trauma and mental health needs to prevent further episodes of homelessness is supported by other researchers (Waldbrook, 2013; Petersen & Parsell, 2014; Kaleveld et al., 2018; Phipps et al., 2019) and echoed in The Lancet as part of World Homeless Day ("Housing and homelessness as a health crisis" [Editorial], 2019).

The study also addresses the need for specialized service models and programs designed to address the unique needs of this cohort of women and

supports the findings of Petersen & Parsell (2014) who identified the lack of designated programs or service models for older women in their report for the Mercy Foundation. The following quote from a Delphi Panel member highlights the need for specialist approaches:

> *"This is extremely important research identifying the health impacts on women of being homeless or at risk of homelessness and will strongly add to a better understanding of the need for specialist approaches to housing and services for older women"* (SHSP).

Throughout this study, the researcher was actively involved in advocacy and agenda setting to bring the issue of older women's homelessness and their health needs to the attention of key policy decision makers. As outlined in the Prologue to this study, this has included membership of the

- National Older Women's Housing and Homelessness Working Group whose report "Retiring into Poverty - A National Plan for Change: Increasing Housing Security for Older Women" which received tri-partisan support at its launch in Parliament House Canberra (Parliament of Australia) in August 2018;

- WA Reference Group for the Ageing on the Edge Older Persons Homelessness Prevention Project, whose report, "One rent increase from disaster - Older Renters Living on the Edge in Western Australia" was launched by the Minister for Child Protection; Women's Interests; Prevention of Domestic and family violence; Community Services in Parliament House, Perth in August 2019: and

- WA Women's Health and Wellbeing Policy Working Group, which was launched by the Minister for Health, Government of Western Australia in September 2019.

Such evidence-based advocacy is paramount given that the 2016 Census revealed the number of older homeless women increased by 31% compared to the previous census figures (ABS, 2018). The outcomes of this study help fill a gap in the understanding the issues and health needs facing older homeless women.

9.3 Strength and weaknesses of the study

As with other cross-sectional studies, this study has some limitations (Sedgwick, 2014). While every attempt was made to recruit a representative sample of older homeless women into the study, the process required representatives from the specialist homeless services to identify and encourage homeless women to meet with the researcher and participate in the research. While the pool of 22 women involved suggests a heterogeneous sample, there may be a selection bias that could impact of the generalizability of the study's findings to the wider older homeless women living within the Perth metropolitan area and across Australia.

The study targeted older women specifically and thus it is not possible to compare the findings with other homeless sector groups including males and young people. That said of course, broader generalization was not the intent of this study as it sought to understand the specific needs of older women, although some of the issues raised may also be relevant to younger homeless women and homeless men.

As a cross-sectional study, this study did not seek information that would provide a longitudinal insight into the specific causes of them becoming homeless or the impact of pre-existing healthcare needs. Furthermore, there was no comparison made between the self-reported health and health service utilization with other parts of the homeless or wider community, making it impossible to compare and contrast with others.

In regard to the women's health needs, recall bias may have impacted on some of the health information sought from the study participants as these conditions were self-reported by the women themselves in a simple questionnaire format and not from their medical records.

Despite its potential limitations, the study also has a number of strengths. Although a study group may be considered relatively small from a quantitative perspective, as a qualitative investigation the amount and quality of data was robust and rich from in-depth interviews and it is one of the larger studies in this field. Due to the use of a broad social determinants framework and careful study design that used a two stage process to interview the women to establish their

trust and interview representatives from the specialist homelessness services and healthcare sectors, the information gathered by this study is both comprehensive and reliable. The cross validation of issues raised by women with information provided by the SHSP and HCP also strengthened the development of the themes derived from the interview feedback and provided insights into potential solutions of the issues. Similarly, there was good representation of key stakeholder groups on the Delphi Panel that both supported the key findings of the study and its recommended actions.

Another potential strength of this study was the willingness and enthusiasm of the women to share their experience as they said they felt that by telling their story, this might help other women who found themselves in a similar situation.

9.4 Recommendations for further research

During the course of this study, several important issues were identified that fell outside of the scope of the current study but would be worthy of further exploration. These included the identification of specific challenges faced by older Aboriginal women who become homeless. It is suggested that further research be undertaken in conjunction with ATSI agencies, healthcare providers and homelessness service providers to explore accommodation options for older Aboriginal women experiencing homelessness in the Perth metropolitan area, especially those who have lost links to their homeland and family in rural and remote WA.

This study also identified the importance for early intervention to minimise the impact of homelessness on the women's health and the likelihood of entering into a cycle of homelessness. Research into awareness raising strategies for healthcare providers to identify women at risk of homelessness and those who may have recently become homeless so they can be more rapidly linked to support services needs exploring.

Given the high proportion of women in the current study that were subject to family and domestic abuse, the sequela of compounding emotional and mental health disorders as a result of DV, and the subsequent link to homelessness, should be examined on a wider scale. Further investigation is required to identify

strategies for better understanding the long-term impact of domestic violence, including strategies for healthcare service providers to ask older women about their experience of domestic violence and referral pathways. Further exploration is also required to address the service support needs of the increasing numbers older women escaping violence.

9.5 Concluding remarks

This study has identified a range of actions to help address and improve the provision of healthcare to older homeless women. While examples of new and innovative services have started to emerge to address the needs of the homeless population, the Expert Panel emphasized the need for development of structural solutions that incorporated intersectoral collaboration across commonwealth and state government funded agencies providing health, housing and social support services. The Panel also recommended that policy and service delivery needed to be developed within a social determinants of health framework that included collaboration and involvement of women with lived experience of homelessness.

The importance of implementing these changes within a social determinants of health framework that addresses the social and economic factors that impact on health outcomes has been recently recognized locally as part of the Sustainable Health Review (Government of Western Australia Department of Health, 2019a) and Western Australian Women's Health and Wellbeing Policy (Government of Western Australia Department of Health, 2019b), nationally in the National Women's Health Strategy 2020-2030 (Australian Government Department of Health, 2018) and internationally (National Academies of Sciences, Engineering, and Medicine, 2019).

Perhaps more importantly, the need to address homelessness as an integrated strategy is reflected in the recently released Western Australia's 10-Year Strategy on Homelessness 2020-2030 by the Department of Communities which calls for a coordinated and integrated approach across regional and metropolitan WA to prevent and end homelessness in this state (Government of Western Australia Department of Communities [WADC], 2019a & 2019b). This strategy was developed with representation from the homeless sector, the

community and people experiencing homelessness (Western Australian Alliance to End Homelessness, 2018; Kaleveld et al., 2019).).

The study demonstrates the intrinsic links between homelessness and health and the influence of the social determinants of health on women's lives. The older women in this study had existing and ongoing complex health issues which had become exacerbated by their experience of homelessness. The study highlights the importance of increasing the provision of safe affordable housing before older women reach crisis, and the need for wrap-around social and healthcare support services to prevent them becoming homeless again. The study also stresses the need for the provision of non-judgemental and supportive health care services and recommends that policies and integrated service models should be developed within a social determinants of health framework.

As pointed out by Clifford et al. (2019), policy development in Australia has been primarily advanced by the homelessness sector. Moving forward, homelessness is a health problem and needs to be viewed as such by the policy makers and health practitioners. Whilst there is clearly a need to address the structural contributing factors to homelessness, given the impact of the social determinants of health, there is also a need for the health sector to have greater involvement in driving systemic policy responses to homelessness.

Available evidence suggests that the factors influencing homelessness in older women are similar in WA compared to those of other older Australian women. It also seems likely that their health needs and barriers to accessing healthcare services will also be similar to the national situation, making findings from this study meaningful across the country. The outcomes from this study will contribute to the momentum occurring in Western Australia and elsewhere by providing clear direction to the healthcare sector on the need for further policy intervention to improve the lives of older women experiencing homelessness.

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APPENDICES

Appendix A

Approval Letter HREC UNDA

THE UNIVERSITY OF NOTRE DAME AUSTRALIA
CELEBRATING 25 YEARS 1989-2014

19 Mouat St (PO Box 1225) Fremantle WA 6959
+61 8 9433 0555 | enquiries@nd.edu.au

26 July 2016

Professor Jim Codde & Ms Gloria Sutherland
Institute for Health Research
The University of Notre Dame, Australia
Fremantle Campus

Dear Jim and Gloria,

Reference Number: 016100F

Project title: "Study of the Impact of Homelessness on the Health Status and health needs of older women in the Perth Metropolitan area."

Your response to the conditions imposed by the university's Human Research Ethics Committee, has been reviewed and assessed as meeting all the requirements as outlined in the *National Statement on Ethical Conduct in Human Research* (2014). I am pleased to advise that ethical clearance has been granted for this proposed study.

Other UNDA students and researchers identified as working on this project are:

Name	School/Centre	Role
A/Prof Caroline Bulsara	Institute for Health Research	Co-Supervisor

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Signature Redacted

Dr Natalie Giles
Research Ethics Officer
Research Office

cc: A/Prof Gerard Hoyne, SRC Chair, School of Health Sciences.

Appendix B

Amendment to Research Approval Letter

THE UNIVERSITY OF NOTRE DAME AUSTRALIA | CELEBRATING 25 YEARS 1989 - 2014

19 Mouat St (PO Box 1225) Fremantle WA 6959
+61 8 9433 0555 | enquiries@nd.edu.au

13 December 2016

Professor Jim Codde & Ms Gloria Sutherland
School of Health Sciences
The University of Notre Dame Australia
Fremantle Campus

Dear Jim and Gloria,

Reference Number: 016100F

Project Title: "Study of the Impact of Homelessness on the Health Status and health needs of older women in the Perth Metropolitan area."

Your application for an amendment to your approved research project has been reviewed by the university's Human Research Ethics Committee in accordance with the *National Statement on Ethical Conduct in Human Research* (2007, updated May 2014). I am pleased to advise that ethical clearance has been granted for the proposed changes.

Other UNDA students and researchers identified as working on this project are:

Name	School/Centre	Role
A/Prof Caroline Bulsara	Institute for Health Research	Co-Supervisor

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Signature Redacted

Dr Natalie Giles
Research Ethics Officer
Research Office

cc: Prof Gerard Hoyne, SRC Chair, School of Health Sciences

Appendix C

Approach Letter to Organisations from Director, Contract Branch, DCPFS

Subject: RE: Re specialist homelessness service providers: study on the impact of homelessness on the health status and health needs of older women in Perth

Hi Gloria,

Thank you, the information you sent through is sufficient. FYI, the following message will be sent to metro SHS agencies this afternoon.

Signed xxx

Service Standards and Contracting Directorate
Department for Child Protection and Family Support
Level 1, 189 Royal Street, East Perth WA 6004

Government of Western Australia
Department for Child Protection
and Family Support

Dear Colleagues,

Your services may soon be contracted by Gloria Sutherland with a request to participate in an on-line survey.

Gloria is undertaking research as part of her PhD to document the health needs of the increasing number of older women experiencing homelessness in the Perth metropolitan area. The research seeks to determine how the health of women over 50 is impacted by becoming homeless; how it may influence their homelessness; and whether available health services adequately address the needs of this sub-population. The research has Ethics Approval from the University of Notre Dame.

To commence the study, Gloria will be contacting a number of specialist homeless services with a brief online survey. The survey endeavours to gain baseline information about these services provided to the homeless and advice about how their clients access health care services. Your assistance in completing the survey would be appreciated.

Katrina Vernon

Director
Non Government Policy and Funding Division
Service Standards and Contracting Directorate

Appendix D

Email Invitation from Researcher to Complete Online Survey

Subject: Requesting your participation in an on-line survey - Study of the Health Needs of Older Women Experiencing Homelessness

Dear .....

I am undertaking research on the health needs of older women (aged 50 and over) who are experiencing homelessness in the Perth metropolitan area. I am seeking to determine how their health both influences and is affected by their becoming homeless, and if current health services are adequately addressing their needs. I am completing this work as a PhD candidate at the University of Notre Dame Australia in a study that has been approved by the University's Human Research Ethics Committee.

The purpose of this survey is to gain baseline information about the homelessness services in the Perth metropolitan area that support older women, and the availability of health care for their clients. I will subsequently interview representatives of those homelessness service providers that do provide services for older women, key healthcare providers and older homeless women themselves.

I would greatly appreciate your completing this short survey or forwarding it on to those program managers within your organisation to whom it is more relevant. You can access the survey by clicking on the link and it should only take 15 minutes of your time. The information will be kept confidential and individual responses will not be identified in any report. Your input would be very valuable to me in defining exactly what services are available and provided to older homeless women.

Click here for survey

Kind regards

Gloria Sutherland

PhD Candidate
Institute for Health Research

Appendix E

Online Survey of Specialist Homelessness Service Providers

Study of Impact of Homelessness on the Health Needs of Older Women in the Perth Metropolitan Area

The purpose of this survey is to gain baseline information about the homelessness services in the Perth metropolitan area that provide for older women, and the availability of health care for their clients. The results of the survey will be used to identify those specialist homelessness service providers that do provide services for older women in order to undertake interviews with key contacts.

Page 2 - Qualifying Population

1. Please enter your organisation's name.

2. What is the name of this service/ program?

3. Please enter the locations (suburbs) where you deliver services.

* 4. Does you organisation provide services (other than health specific services) for women aged 50 years and older?

- ◯ Yes
- ◯ No

5. If you do provide services for older women please describe these briefly.

Page 3 - Qualifying Health Services

* 6. Does your organisation deliver health care to older women (50 years+)?

- ◯ Yes
- ◯ No

Homelessness Service Providers Details

7. Please describe the kinds of health care services your organisation provides for older women? For example, nursing, GP, dentistry, counselling, podiatry, optometry, etc. Please list each service on a new line.

Enter health service description here
Enter health service description here
Enter health service description here
Enter health service description here
Enter health service description here
Enter health service description here
Enter health service description here
Enter health service description here
Enter health service description here
Enter health service description here

8. Approximately how many older women (50 years+) does your organisation deliver health services to in an average calendar month?

- ◯ Between 1-5 women
- ◯ Between 5 - 10 women
- ◯ Between 10 - 20 women
- ◯ > 20 women
- ◯ Other (please specify)

9. In your opinion, approximately what percentage of your current client base comprise older women (50 years+)?

Health Service Provider Referral Details

* 10. Does your organisation refer to other health services?

- ◯ Yes
- ◯ No

11. In addition to health services that you provide, please list below the name of any other health service providers your organisation refers older women to. Please enter as many as apply (e.g. GP, counselling services, drug and alcohol services, mobile clinics, etc)

Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	
Enter Organisation / Practitioner's Name Here	

12. Why did your organisation choose to refer older women to thehealth services listed in the previous question? Please tick as many as apply.

- [ ] We Don't Offer The Service
- [ ] Accessibility
- [ ] Reputation
- [ ] Quality
- [ ] Cost to the Client
- [ ] Cost to our Organisation
- [ ] Appropriateness of Service
- [ ] Meet the Client's Specific Health Needs
- [ ] Gender specific services
- [ ] Other
- [ ] Other (please specify)

13. Does your organisation refer older women to any of the following services (please include referrals and visiting services). Please select as many as apply.

- [ ] Housing / Accommodation Services
- [ ] Financial Support / Planning
- [ ] Employment Support
- [ ] Counselling
- [ ] Food Services
- [ ] Clothing Services
- [ ] Legal Services
- [ ] Advocacy Services
- [ ] Emergency Crisis Relief
- [ ] Day Centre Social Activities
- [ ] Training in Lifeskills
- [ ] Security and safety

Other (please specify)

14. Can you please provide the name(s) of anyhomelessness services to whom you refer older women to meet their accommodation needs?

Service 1	
Service 2	
Service 3	
Service 4	
Service 5	
Service 6	
Service 7	
Service 8	
Service 9	
Service 10	

* 15. Does your organisation follow your client's progress after referral?

- ◯ Yes
- ◯ No
- ◯ Not sure / don't know

* 16. Is your organisation willing to participate in a follow up interview (telephone or in person) with the researcher to further explore the health needs of older homeless women in Perth?

- ◯ Yes
- ◯ No

Homelessness service providers comments

17. Do you have any other comments to add regarding your service and older homeless women that you would like to add?

Follow Up Interview Contact Details

18. Please provide the contact detail of your organisation's representative for further discussions.

Key Contact Person	
Organisation	
Contact Email Address	
Contact Phone Number	

Appendix F

Flyer Inviting Women to Participate in the Study

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Study of older women's health needs

We need to hear your views and experiences.

Gloria Sutherland is a researcher from the University of Notre Dame and is conducting a study into the experiences of women aged 50 and over. This is the first study in Western Australia to explore the health needs of older women who are experiencing homelessness and their experiences of health services.

Gloria will be talking with women at this centre over the next weeks (insert dates and times).

The information from her study will be used to better understand the needs of older women and plan for future health services.

If you think you would like to help, please feel free to contact Gloria on xxx (mobile number) or A/ Prof Caroline Bulsara on xxx (office number) from Notre Dame who can explain the study to you in more detail, or contact xxx at x Service and put your name forward.

Your participation and answers will be strictly confidential.

Appendix G

Participant Information Sheet for Women in the Study

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

PARTICIPANT INFORMATION SHEET FOR WOMEN IN THE STUDY
(to be read to potential participants by the researcher if requested)

Study of the Impact of Homelessness on the Health Status and Health Needs of Older Women in the Perth Metropolitan Area.

You are invited to part of this research project seeks to investigate the health needs of older women. All your answers are strictly confidential and will not be shared with anyone else.

What is the project about?
The purpose of this research is to understand the health needs of older women (aged 50 and over) in the Perth metropolitan area who are experiencing homelessness. You will be asked about your current health conditions, where you get health care, and how easy or difficult it is for you to access this care.

The researcher will also be interviewing healthcare and homeless service providers in the metropolitan area to seek their views on the current way services are provided and how they could be improved.

Who is undertaking the study?
This research is being undertaken by Gloria Sutherland as part of her Doctor of Philosophy (PhD) studies at The University of Notre Dame Australia, under the supervision of Professor Jim Codde, Associate Professor Caroline Bulsara and Professor Suzanne Robinson from Curtin University.

What will I be asked to do?
If you agree to take part in this research study, you will be asked to complete a form that asks some basic information about yourself and your health. You will be also be asked a series of questions about your experiences in a face to face interview.

Each interview will take approximately 60 minutes of your time, and the information will be digitally recorded. This recorded information conducting the interviews.

After this, you may be asked to take part in a follow up focus group interview to confirm the key issues and recommendations that we find from the first interview. This should only take 30 minutes and will also be digitally recorded.

All recordings will be kept confidential, is only for the use of the researcher and will be destroyed when the study is complete.

Are there any risks associated with participating in this project?
There are no specific risks anticipated with participation in this study. However, if you find that you are becoming distressed or feeling anxious, you are definitely free to withdraw at any time. If these feelings persist after the completion of the session, arrangements will be made for you to access support from your provider or for you to see a counselor or a medical practitioner at no expense to you.

What are the benefits of the research project?
The information collected by this study will be used to help improve the way health care services are provided to older women experiencing homelessness in the metropolitan area. While there may be some short term benefits in the provision of healthcare services for women, it is anticipated much of the change will be longer term.

What if I change my mind?
Participation in this study is completely voluntary. Even if you agree to participate, you can withdraw from the study at any time without prejudice. If you withdraw, all information you have provided will be erased. Your relationship with any of your service providers will not be impacted in any way on your participation or withdrawal from this study.

Will anyone else know the results of the project?
Information gathered about you will be held in strict confidence, which will only be broken if required by law. The results of the study will be published in a thesis and possibly a journal article but you will not be identifiable.

Information collected and stored on audio files, written notes or computer files will be carefully secured at all times by the researcher. Data will only be accessed by the researcher.

In keeping with legal requirements, once the study is completed, the data collected from you will be de-identified and stored securely in the Institute for Health Research at The University of Notre Dame Australia for at least a period of five years. The data may be used in future research but you will not be identifiable.

Will I be able to find out the results of the project?
Once we have analysed the information from this study, a written summary will be made available to all participants. You can expect to receive this feedback in 2017.

Who do I contact if I have questions about the project?
If you have any questions about this project please feel free to contact either myself gloria.sutherland@nd.edu.au or my supervisor, jim.codde@nd.edu.au. My supervisor and I are happy to discuss with you any concerns you may have about this study.

What if I have a concern or complaint?
The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 016100F). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

How do I sign up to participate?

If you are happy to participate, please sign both copies of the consent form, keep one for yourself.

Yours sincerely,

Gloria Sutherland

Appendix H

Consent Form for Women in the Study

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

CONSENT FORM FOR WOMEN IN THE STUDY

Study of the Impact of Homelessness and Health Needs on the Health Status of Older Women in the Perth Metropolitan Area.

- I agree to take part in this research project.
- I have read the Information Sheet provided and been given a full explanation of the purpose of this study, the procedures involved and of what is expected of me.
- I understand that I will be asked to provide some basic personal information in a questionnaire and then answer some questions about my health and health service needs in face-to-face interview.
- I understand our conversation will be digitally recorded and that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I understand that I may also be asked to participate later in a group discussion to provide feedback on the findings of the study.
- I agree that any research data gathered for the study may be published but my name and other identifying information is not disclosed.
- I understand that research data gathered may be used for future research but my name and other identifying information will be removed.
- I understand that I may withdraw from participating in the project at any time without prejudice, and that my relationship with any my service providers will not be impacted on my participation in this study.

Name of participant			
Signature of participant		Date	

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	

Consent Form template June 2015

Appendix I

Survey for Older Women Experiencing Homelessness

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Survey for Older Women Experiencing Homelessness

_____

Homeless Service Location

_____

Today's Date

1. Personal Information (All responses confidential)

First Name	Last Name	Gender	Age

Address / Living Arrangements

☐ A Carer

6. Are you / or have you recently been a carer for family member or friend?

☐ Yes
☐ No
☐ Can't remember
☐ Other, please write here .....

_____

Phone

2. Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes | ☐ No | ☐ Unsure

3. In which country were you born?

☐ Australia

☐ Unsure

☐ Other, please write here .....

1

4.. Which of the following best describes your highest level of education?

☐ Primary School | ☐ Some Secondary School | ☐ Completed Secondary School
☐ TAFE apprenticeship or similar | ☐ University Bachelor Degree or Higher | ☐ Did not go to school
☐ Unsure

5. Can you tell me about your family and support

Do you have:

☐ Family who you are close to
☐ Children
☐ A Partner
……

7. Do you have supports in the community? For example, do you belong to:

☐ Community groups
☐ Have extended family who support and help you

☐ Friends who support and help you

☐ Other, please write here…….

8. So that I can understand your accommodation / housing experiences:

Which of the following describes your current living arrangements?

☐ Sleeping rough or in non-conventional accommodation
☐ Short term or emergency accommodation, due to a lack of other options
☐ Medium term/transitional accommodation e.g. lodging or boarding house
☐ Private rental
☐ Homeowner
☐ Other

What were your living arrangements in 3 months ago?

☐ Sleeping rough or in non-conventional accommodation
☐ Short term or emergency accommodation, due to a lack of other options
☐ Medium term/transitional accommodation e.g. lodging or boarding house
☐ Private rental
☐ Homeowner
☐ Other
☐ Don't know/ can't remember

Which of the following best describes your living arrangements 12 months ago?

☐ Slept rough: no shelter or accommodation
☐ Slept in car
☐ Your own private rental/ home owner
☐ Public housing or community housing
☐ Living with extended family, friends or acquaintances because you had nowhere else to live
☐ Short term, crisis or emergency accommodation for people experiencing homelessness (eg shelter, refuge or emergency accommodation for less than 3 months)
☐ Medium-long term accommodation for people experiencing homelessness (eg shelter, refuge or emergency accommodation for more than 3 months)
☐ Temporary accommodation (eg caravan, hostel, boarding house) slept rough: no shelter or accommodation
☐ Accommodation in an institutional/ residential facility setting .....
☐ Other (please write here) .....

9. Personal safety concerns

Are you currently or have you ever experienced any violence in your family? ☐ Yes | ☐ No | ☐ Unsure

Have you been a victim of violence or aggression during the time you have been homeless? ☐ Yes | ☐ No | ☐ Unsure

Have you needed to seek medical attention / see the doctor or nurse because of physical injuries from domestic abuse

- At home? ☐ Yes | ☐ No | ☐ Unsure
- Or when you have been homeless? ☐ Yes | ☐ No | ☐ Unsure

Have you experienced any other trauma? (eg accident, street violence) ☐ Yes | ☐ No | ☐ Unsure

10. Basic Health Related Information

In general, how would you describe your current health?

☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

How does your current health compared to that of a year ago?

☐ Much better ☐ Somewhat better ☐ About the same
☐ Somewhat worse ☐ Much worse ☐ Don't know

Do you currently or have you ever suffered from any of the following? (If yes, please give additional information)

Depression	☐ Yes | ☐ No | ☐ Unsure	.....
Other mental health concerns	☐ Yes | ☐ No | ☐ Unsure	.....
Alcohol and drug use problems	☐ Yes | ☐ No | ☐ Unsure	.....
Sleeping problems	☐ Yes | ☐ No | ☐ Unsure	.....
Injuries and trauma	☐ Yes | ☐ No | ☐ Unsure	.....
Fatigue	☐ Yes | ☐ No | ☐ Unsure	.....
Chronic pain	☐ Yes | ☐ No | ☐ Unsure	.....
Arthritis or joint disease	☐ Yes | ☐ No | ☐ Unsure	.....
Osteoporosis or bone disease	☐ Yes | ☐ No | ☐ Unsure	.....
Heart disease	☐ Yes | ☐ No | ☐ Unsure	.....
Diabetes	☐ Yes | ☐ No | ☐ Unsure	.....
Skin conditions	☐ Yes | ☐ No | ☐ Unsure	.....
Stomach/Digestive disorders	☐ Yes | ☐ No | ☐ Unsure	.....
Lung problems/ asthma	☐ Yes | ☐ No | ☐ Unsure	.....
Conditions of the ears, eyes, nose, throat	☐ Yes | ☐ No | ☐ Unsure	.....
Dental / teeth problems	☐ Yes | ☐ No | ☐ Unsure	.....
Cancer	☐ Yes | ☐ No | ☐ Unsure	.....
Epilepsy	☐ Yes | ☐ No | ☐ Unsure	.....
Bladder problems	☐ Yes | ☐ No | ☐ Unsure	.....
Sexually transmitted infection	☐ Yes | ☐ No | ☐ Unsure	.....
Abnormal Pap smear	☐ Yes | ☐ No | ☐ Unsure	.....
Breast problems	☐ Yes | ☐ No | ☐ Unsure	.....
Other women's health problems	☐ Yes | ☐ No | ☐ Unsure	.....

What is your most significant health problem and where do you go to get care for it?"

.....

11. Have you used any of the following health care services since you became homeless? (If yes, please give additional information)

GP / doctor	☐ Yes | ☐ No | ☐ Unsure	.....
Mobile GP service (eg Street Doctor)	☐ Yes | ☐ No | ☐ Unsure	.....
Counselling services (Psychological)	☐ Yes | ☐ No | ☐ Unsure	.....
Counselling (general)	☐ Yes | ☐ No | ☐ Unsure	.....
Counselling services (Sexual Assault)	☐ Yes | ☐ No | ☐ Unsure	.....
Mental health services	☐ Yes | ☐ No | ☐ Unsure	.....
Alcohol & Other Drugs (AOD) services	☐ Yes | ☐ No | ☐ Unsure	.....
Women's health services	☐ Yes | ☐ No | ☐ Unsure	.....
Hospital	☐ Yes | ☐ No | ☐ Unsure	.....
Emergency Department	☐ Yes | ☐ No | ☐ Unsure	.....
Physio/ Podiatrist / optometrist	☐ Yes | ☐ No | ☐ Unsure	.....
Dentist	☐ Yes | ☐ No | ☐ Unsure	.....
Cultural specific services	☐ Yes | ☐ No | ☐ Unsure	.....

☐ Other (please write here) .....

Thank you for your input.

I am now going to ask some questions regarding your health and your experiences.

Appendix J

Interview Guide for Older Women Experiencing Homelessness

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Interview Guide for Older Women Experiencing Homelessness

During this interview (following on from Part A) participants will be asked questions utilising a semi structured format.

The following questions have been designed to build upon the information from the interview in Part A to:

explore the health needs of older women experiencing homelessness;

how health influences and is impacted by their becoming homeless;

determine if current health services are adequately addressing their health needs.

RQ 1 What are the health care needs of older women who are experiencing homelessness?

RQ 2 How has their experience of becoming homeless (including the contributing factors, the duration and recency of their becoming homeless), impacted on their health needs and their experience of health services?

RQ 3 What are the barriers and enablers to accessing health care for these women?

RQ 4 From the women's perspective, are their health needs being met by current service delivery?

RQ 5 What are the priorities and recommendations for potential alternative services / how to improve access to health services for this population?

_____

Homeless Service Location

_____

Today's Date

1

QUESTION 1. What does it mean to you to be healthy?

QUESTION 2. What would you say are your main health needs now?

QUESTION Q3 Tell me about your experience of homelessness?

Explore aspects of the woman's experience of homelessness including

- how long
- how recent
- **reasons** for her becoming homeless – include trauma – physical, emotional, financial

QUESTION Q4 If you think about your homelessness, would you say that this has positively or negatively affected your health? (including current accommodation / living arrangements)

Prompts

- If you think about your health needs in previous years, would you say that your health needs have changed since you became homeless? If so, in what way?
- For example, have you experienced more ill health? Or is your health better?
- How do you feel about this?
- Where did you go for health services before you were homeless?
- Do use the same health services now?

QUESTION Q5 Have you used any health care services since you became homeless?

Explore

- If so, which health care services?
- Where do you go, or have been to seek assistance for your healthcare needs?
- How often do you need to see the healthcare provider? / GP
- Do you use hospital services? Which hospital service? How often and why
- Do you use special health services, how often and why?
- eg women's health
- eg mental health
- eg cultural specific services

QUESTION 6 What factors are the most important for you to obtain and maintain good health and well-being?

Prompts:

- finding a place to live – maintaining place in stable accommodation - Meeting accommodation needs
- balancing costs eg costs of accommodation, food, medication
- Supports
- Environment
- Understanding / not feeling embarrassed or ashamed to say they are homeless and to ask for help
- Education
- Diet
- Costs/ money

QUESTION 7. Has anything prevented you from receiving the health services you needed?

Prompts

- Meeting accommodation needs and what kind
- Costs including rent medication food
- Location and availability of health services
- Supports
- Environment
- Understanding of staff
- Education
- Diet
- Ongoing access to healthcare
- Safety and security
- Family
- Personal relationships
- Other
- Feeling embarrassed to ask for help

QUESTION 8 Thinking about your past experiences with health services:

Could you tell me about the health services you have used both before and after you became homeless?

Would you share some of the good / positive experiences and any that were perhaps not so good / negative?

Considering both the current and past health services you used, what was different about the experiences that made them 'good' or 'bad' for you?

Prompts

- Ongoing access to healthcare
- Safety & security
- Family
- Personal relationships

QUESTION 9 Would you say that this service (where the interview is taking place) has been able to assist you to access the health care/ health services you need?

Prompts:

- client relationship with homeless services
- further explore client relationship with health care providers
- cooperation between staff
- cooperation between homeless services and healthcare providers
- access to services – coordination of services
- further exploration of effectiveness and satisfaction of client / clinician relationship if required

QUESTION 10 Has anything prevented you from receiving the health service you needed?

Prompts:

- cost
- mobility
- access
- competing priorities
- attitude of staff (this may come out in the previous question but if not, then worth asking)

QUESTION 11 Do you have any suggestions for improving health care services for you and women in a similar position?

QUESTION 12 Is there anything else you would like to say about looking after your health or about providing health care for older women who are experiencing homelessness?

Appendix K

Profiles of the Women Participants

NOTE: The names of the 22 women have been changed for confidentiality reasons and fictitious names have been created.

Ruby

Ruby, aged 71, became stranded in the city after coming to Perth from the Murchison area for treatment for an eye injury 10 years ago after being hit in the eye by her partner. She visited a local GP who advised her to go to Perth for medical treatment. She packed up her belongings and handed in her State Housing key to her home. She regretted this move and said that she believed that she should have just left her house and travelled up and down to from the country to the city for treatment. She was initially placed in an inner city ATSI refuge, moved out and has been living intermittently on the streets of Perth and Midland for the last 10 years. She was living in transitional accommodation at the time of interview. Ruby was a grandmother and great grandmother.

Brenda

Brenda, aged 62, was a refugee who fled Uganda and was settled into WA as a refugee, having lost her parents and her husband in the Ugandan wars. She arrived in Perth 20 years ago with her 4 children (2 boys and 2 girls) and then moved to Queensland with her daughters several years ago. She had recently returned to Perth from Queensland to try and help her sons and their families who were still living in Perth. She was paying her share of rent to her son but unbeknownst to her, the rent was not being paid to the landlord, so all the family was evicted onto the street. She sought help from a multicultural centre who were unable to help her as they told her she'd been in Australia too long. She approached the Salvation Army who referred her to transitional accommodation, where she was living at the time of interview. Brenda spoke of how having her parents and husband killed had impacted on her and her children, of how they all had experienced racial abuse since coming to Australia and how all her children had attempted suicide at some stage. Her strong Christian faith had provided her with a level of coping.

Stella

Stella, aged 56, was made redundant from her job as an office administrator, then became very ill and developed Lupus Erythematosus. She believed that the combination of both her poor health and age had contributed to her losing her job. She also had PTSD from an earlier abusive incident. She was unable to pay her rent and was evicted from her home, and the stress effect of becoming homeless exacerbated the disease. Stella had recently moved into a short term single social housing unit, after living in transitional accommodation. She spoke of how anxious she had become trying to obtain financial assistance from government social security services, who had advised her that she was still required to keep applying for work. Her health continued to deteriorate and now she was unable to walk without her walking frame. Her autoimmune disease (Lupus) had worsened.

Sarah

Sarah, aged 55, moved to Australia 30 years ago from New Zealand and had 3 children. Her husband became abusive and her relationship broke down. She moved out of the family home and with the support of her parents, managed to raise her children. However, she had untreated bipolar disorder. She left her children in the care of her parents and borrowed her sister's car in which she slept. She coped financially but was not taking her medication and used her medication money to buy food. While she was living in the car, she was too ashamed to tell her parents and her children where she had gone and so lost touch with them, returned the car to her sister, having decided to go it alone onto the streets. She did not know where to go for help initially but now with the support the of *50 Lives 50 Homes* program, she was renting small a home unit, has begun to have regular care and support and is back on her prescribed medication. She has reconciled with her family.

Jennifer

Jennifer, aged 69, came from a wealthy background and had been a high school teacher. Jennifer became depressed after a series of events, including, her marriage breakdown, a bitter property dispute, her sister committing suicide

and severe side effects to a medication she was taking to give up smoking. She was admitted into psychiatric care for 3 years. She had 5 children but is only now in contact with one of them, a son who lives interstate. She briefly moved into rental accommodation with her daughter after her discharge from psychiatric care but this arrangement but didn't work out. She said she was still in a state of shock and disbelief at what has happened to her, had no funds and no idea how to access social security. She was living in transitional accommodation at the time of interview. She said her greatest sadness was no longer having a home where she could have her children and grandchildren come and stay with her.

Tanya

Tanya, aged 52. After her relationship broke down, she moved out of her house and left her children with her parents. She couch-surfed, then lived in a car, lost the car and then lived in an inner-city car park for 4 years. She initially slept in her car over which time she became addicted to the drug Kronic (synthetic cannabis) and alcohol. She had accumulated $10,000 in parking fines. While Tanya was sleeping rough, she was caught stealing food from a supermarket. She was given a community-based order by the magistrate to help get her off the streets. At the time of interview, she was living in transitional accommodation and doing a TAFE Certificate 3 course to get back into the workforce and so she could help other women who have become homeless.

Angela

Angela, aged 50, lived in her car on a bush block near an outer suburb, having moved into her car after a family abuse incident. She had also lived on the streets and spoke of how dangerous it was, particularly at night and how her possessions were continually being stolen. Angela spoke of the costs associated with maintaining a car and that she found living on the streets was more expensive than paying rent, having to purchase pre-packaged foods as she had nowhere to store her food. She felt very saddened that having stayed home to raise 3 children she was now homeless and living in her car and on the streets.

Gwenda

Gwenda, aged 65, a previously registered nurse, recalled her experience of domestic violence and the breakdown of her first marriage and a bitter financial dispute. She remarried but due to financial struggles raising children in a blended family, this marriage also ended. She lived in a rental property but couldn't afford the rent, then moved into her car and then into cheap backpackers' accommodation. She was living in a short term unit at the time of interview. Gwenda was selling *The Big Issue* which she said supplemented her pension and which helped her both financially and emotionally. She was endeavouring to reconcile with her now grown up children.

Gina

Gina, aged 51, had been living on the streets for the past 13 years. At the time of interview, she was staying in a night shelter and spoke of how she was an Aboriginal Elder and was trying to support other homeless people on the streets. She was very concerned about her family, especially her granddaughters and had agreed to be interviewed because she felt her story might help prevent other women, including her granddaughters, from becoming homeless. She had a range of complex health issues for which she was receiving treatment and support.

Rose

Rose, aged 52, had been living on the streets of the inner city for the past 18 months. Rose's daughter lived on the streets with her. Rose said she preferred to be independent and stay on the streets rather than staying at families' places because she did not want to be a burden on her extended family. She told of how her day unfolds, sleeping rough in the inner city, of how she wakes up from wherever she has found shelter, goes to Tranby's for breakfast, may take a bus to Ruah and then to Beaufort Park for lunch. At the time of interview, Rose said that her handbag had been stolen and she only had the clothes she was wearing and a couple of blankets. She was waiting until she got a new pension card and for pension day, so she could go with her daughter to buy some new clothes from an op shop.

Katy

Katy, aged 60, was born in Bosnia and had virtually no education. She married and came to Australia 30 years ago and lived in the Murchison area on a rented farm with her husband who was physically and emotionally abusive. He isolated her, forcing her to lose contact with her family in Bosnia and often threatened to kill her including if she tried to see a doctor. Her husband committed suicide 10 years ago which left Katy living on her own on the farm, unable to speak English with no idea of how to find other accommodation. Eventually, she moved to the city to live with a Bosnian female friend, but this became untenable. She was then referred by a female GP to transitional accommodation. Katy's daughter who was born in Australia has subsequently moved to Bosnia and Katy was desperate to return to be close to her and her grandchildren. Staff have since advised the interviewer that they have found stable and secure long-term accommodation for Katy.

Denise

Denise, aged 82, came from a wealthy family. She had been living in her own home unit south of the city, with river views. Denise's sister falsified her name on her property title deed, which resulted in Denise having to move out. She moved into backpacker accommodation in the inner city where she had a dizzy spell, so she was sent to Royal Perth Hospital ED. From there she was referred to a suburban hospital and subsequently referred to transitional accommodation. Denise was endeavouring to reclaim her home with the assistance of the case managers at the transitional accommodation hostel who had linked her up with some legal aid. Denise was philosophical but shocked and saddened that her sister would do this to her. She had no children. Denise had recently noticed some memory loss which she attributed to her age.

Amelia

Amelia, aged 71, came from a country town to an outer Perth suburb where she couch-surfed with her family, but this fell through. She went to live on the streets of Fremantle, including a brief stay at some emergency accommodation for women in Fremantle. She then moved to the streets of inner Perth and was

assaulted while sleeping rough. She now lives in a short term unit. Amelia spoke of her complex, chronic health issues including heart disease and mild incontinence. Amelia's daughter has terminal cancer and she was trying to help her financially as well as pay for her own medications and rent.

Beth

Beth, aged 72, was evicted from her rental house in northern Perth suburb that was condemned as it was run down and neglected. The local council declared the house inhabitable, so she moved around the city staying at cheap motels and hostels. She was finally admitted to RPH for chronic health problems and was then discharged onto the street. After she had been discharged from RPH, she spoke of how she stayed out the front of the hospital for some days and had her bag and medications stolen. Eventually she was picked up from the bus stop at the front of the hospital by a bus driver who dropped her at nearby SHSP, who managed to find her a short term unit. She said she was still giving some of her pension to her previous partner whom she saw as her "carer", even though he had taken her money in the past, which she said had caused her to become homeless in the first place.

Mary

Mary, aged 60, became involved with a church group after her relationship breakdown and she ended up in psychiatric care for 20 years. Mary moved out of her home in regional WA and from there to a caravan park in an outer Perth metropolitan suburb for 7 years. While she enjoyed the location of the caravan park, she had found it hard to manage on her own. When she was living in the caravan park, she caught the train into the city, saw the City Farm in East Perth as she went past in the train and decided to "take a look". She then went to the nearby SHSP and they told her about the transitional women's hostel. She filled in the forms, got a referral from a doctor and after a couple of months moved into transitional accommodation.

Dawn

Dawn, aged 66, went overseas on a business trip and came back to find her husband had trashed her house and stolen all her possessions. She became very distressed and was admitted into psychiatric care for a period and then ended up moving from WA to NSW. She came back to WA and eventually found herself on the streets of Northbridge and Perth. At the time of interview, she was living in a short term unit. Dawn, who used to run a successful business and came from a very secure lifestyle, spoke of how hard it was to find herself on the streets of the city, looking for food from charity. She told the story of how she had worked hard all her life and had lost thousands of dollars in assets as a result of her marriage breakdown. She spoke of how she had lost her literacy skills for a period due to the stress she experienced becoming homeless. She spoke of how she was trying to help and give some of her pension to her daughter in palliative care due to terminal cancer. She now found herself trying to help other people who had become homeless. She spoke of how sad she felt trying to help other Aboriginal women in the city who had become stranded after coming down from the country to be with sick family.

Marie

Marie, aged 48, told of her experience of trauma, which began when she was 14 years old. She had been raped and abused by members of a religious sect to which her parents belonged. She still suffered from post traumatic stress resulting from this experience. After moving onto the streets, she became involved in several abusive relationships. She said that her health depended very much on where she was living at the time and that for the past few months on the streets it had deteriorated. She had used heroin and had also been raped while living on the streets. She was no longer using heroin but was still sleeping rough at the time of interview. However, she had just been assisted by a SHSP to find some temporary women's accommodation. Marie said she had found the staff at the SHSP and the Street Doctor staff to be some of the first people she had ever met who listened to her and treated her with respect.

Molly

Molly, aged 54, who had ABI was undergoing court proceedings against her partner who had been charged with beating her until she was unconscious and flown by RFDS to RPH Intensive Care. At the time of interview, she was being assisted by hostel staff and police to prepare for a forthcoming trial whereby her partner had been charged with assaulting her. She felt that her health had improved since moving to the city and into transitional accommodation, having left her violent home environment in a regional WA town. She had separated from her husband some years before. She has a good relationship with her children who visit her at the transitional hostel to provide some back up support. She said the most important thing for her health was to be able to feel safe. She had noticed some memory loss since waking up in intensive care some months prior. She was attending Fiona Stanley Hospital rehabilitation service as a day patient and was hoping eventually to find a little place to rent in the city where she could live and have a dog.

Carol

Carol, aged 60, was living in untenured State Housing accommodation in a suburban location. She first became homeless as a result of escaping domestic violence from her husband. After sleeping rough for a period, she was allocated some accommodation but had been evicted several times due to trying to meet the needs of her family, to whom she is very committed. She currently lives in a small, (un-tenured) one-bedroom State Housing unit, fearful of being evicted again as her neighbour complains to State Housing when she tries to help her family by allowing them to stay for short periods. She said she had been raped when she was 14 and was forced to put her baby up for adoption. She has since been re-united with her son. She said she enjoyed telling her story of how she had been born in a mission but had survived a difficult life and was very close to her family.

Daphne

Daphne, aged 54, moved to Perth from the Kimberley area around 10 years ago after having a lumpectomy at Broome Hospital. She was still grieving the loss of a son who was killed in an accident a few years ago and carried his ashes

with her. After Daphne came to Perth, she was stabbed by a woman in whose house she was couch surfing. She sought medical attention at a hospital ED for the stab wound and was referred to mental health services. She was subsequently referred to an ATSI refuge for a period and then eventually ended up sleeping rough on the streets of Perth. At the time of interview, she was living in transitional accommodation and staff have advised the interviewer that they have found long term accommodation for her.

Pamela

Pamela, aged 52, was a New Zealand Maori woman who came to Australia two years ago to join her brothers. She had worked as a security guard in New Zealand. Pamela converted to Christianity on the flight to Australia and has forged a strong connection to the Salvation Army who have provided her with good support. When she originally arrived in Perth, she found she was unable to stay with her brothers who lived in Perth. She moved onto the streets where she was assaulted, and her ID and all her money stolen. At the time of interview, she was living in a suburb south of Perth, with a local family who attended the same church as her. Because Pamela is New Zealand resident, she has no access to any social security in Australia. She was actively involved in advocating for other Maori people in Australia who are experiencing homelessness.

Alison

Alison, aged 56, spoke of how after 20 years of marriage, her relationship had broken down. She went to Indonesia 8 years ago and married a man there. She became ill living with him in the jungle, and then that relationship also broke down. She was helped by a church group in Java who provided her airfare to Perth. However, when she got back, she became stranded at the airport. She went to stay at a backpackers' hostel in the city, the staff at the hostel suggested she go to the Salvation Army, who subsequently organised for her to access transitional accommodation where she had been living for the past 2 months. Alison did not consider herself to be homeless and did not have "anywhere to live at the moment".

Appendix L

Major themes and elements of their construction

This table shows the relationship between the quotes obtained from the women's interviews and the development of the associated codes, sub-themes and the final major theme.

Sub-theme	Codes	Exemplar quotes
Accommodation and safety		
Accommodation housing Accessing homelessness services Awareness of services	Safe accommodation fundamental to health Somewhere safe to sleep Safety and security Home environment Keeping food safe Health effect of risk of homelessness Getting older	*"A proper home environment to live in ... in a place where I can rest, sleep and relax"* (Woman speaking of main health need) *Basically, to feel safe and secure… knowing that I've got a warm bed at the end of the night."* (Woman speaking of her main current health need) *"Finding a house is the base from which everything else works."* (Medical practitioner) *"It's dangerous out there… it's extremely dangerous and violent."* (Woman who had lived on streets) "*We really, really try to get women off the streets into somewhere that's safe, because the longer they're there, the more trauma they will accumulate, the more difficult it becomes to actually settle them back into a normal life...*" (Medical practitioner) *"My diabetes has gotten worse…because I can't cook and I can't keep fresh food…you've not got a fridge that you can store anything in … you can't go and get fresh fruit and vegies and stuff because you can't afford to buy that stuff every day."* (Woman living in car)

Sub-theme	Codes	Exemplar quotes
		"If I had not taken the initiative to call the Salvation Army I would probably be in the street" (Refugee woman speaking of finding somewhere to live after she was evicted.)
		"*They don't know where to go … they don't know about the services."* (SHSP manager discussing women's difficulty accessing homelessness services due to the lack of awareness of housing and homelessness services.)
		"In this facility we're all 50 and over, we've had a lot of experiences in our lives." (Woman living in older women's transitional accommodation discussing the needs of accommodation specifically for older women.)

Sub-theme	Codes	Exemplar quotes
Women's experience of trauma and abuse		
Past trauma impact on health Trauma since becoming homeless	Family/ domestic violence Not knowing what to do/ who to turn to Physical injury ABI Sexual abuse – harassment	*"There's always a history of extreme trauma, or deprivation …that's probably underlying all homelessness, would be trauma"* (Case worker) *"I had a pretty protected upbringing…so I didn't know how to deal with it"* (Woman speaking of her DV experience) *"I have the memories and the flashback of the bashings all the time."* (Woman diagnosed with ABI after DV assault) *"A lot of women don't talk about it until it's too late, and then they're so far down the ladder that it takes a long time to pick yourself up again … way down… it's a huge problem most of our women don't have bruises and things… they don't go out and see their friends, they don't do so many things and when this all breaks down,…women who are victims of violence…I think their mental health is because of that violence".* (Case worker at women's refuge) *"I blame myself because I was putting myself in that situation. I put myself in a lot of dangerous situations, and around a lot of dangerous people…"* (Woman who spoke of her experience after being sexually assaulted while sleeping rough on the streets.)

Sub-theme	Codes	Exemplar quotes
Impact on a woman's health due to her inability to fulfil her role as family nurturer		
Children family Family impact Family counselling	Children, grandchildren Grief and loss of home and family Estranged / disconnected	*"Women are always worried about their children…"* (Case worker, inner city) *"As I grow older, the main thing in my life is I'm healthier for my grandchildren"* (Aboriginal woman) *"All my children have attempted suicide at one time… eventually the boys became homeless...so I have to make a very drastic decision …should I let the girls suffer because of the choices the boys have made or not so I decide I'll give the girls a chance - the boys are in and out of prison – J's just got out of jail, I need to be here for him. My other son is still on the street…* (Woman evicted onto the street with her son after moving in to help him) *"The fact that I had children. I had kids out there…even though I didn't see them… they were out there. I knew they were there* (Woman speaking of how knowing she had children kept her going - now reconciled after living in car/ streets for 3 years)

Sub-theme	Codes	Exemplar quotes
Mental Health		
Mental health needs Role Alcohol and AOD Fatigue and sleep Mental health services	Mental Grief, loss Impact trauma PTSD Anxiety Depressed Female psychologist/ psychiatrist need	*"The abuse….at the moment, that's the least of my worries. Abuse I can deal with. Physical stuff like that you can deal with. It's the mental/emotional side of it that I find hard to deal with…. Bruises heal. The mental stuff doesn't."* (Woman living in temporary accommodation) *"Most of our ladies, suffer from anxiety and depression…. and because of that, they often experience tiredness, exhaustion, fatigue and a lot of them emotional stress…* (Case worker) *"Most of the residents have some mental illness, and some with schizophrenia."* (SHSP manager) *"Depression/ anxiety is major in almost everyone… homelessness is very traumatising … we're seeing women in transitional accommodation where you have more of the unravelling of long-term things, starting to come to the surface because it's been pushed down for so long, because they're just doing the survival flight or fight thing day after day, after day, after day….then once that drops away then you see all the mental health stuff come up to the surface…we find that depression can creep in and then we find that the trauma that has been suppressed for so long and comes to the surface which can be overwhelming for people."* (nurse)

Sub-theme	Codes	Exemplar quotes
Complex interaction of physical and mental health needs		
Physical health needs Lifestyle and preventive health Women's health specific needs Inter-relationship of health & homelessness Mental health Role of AOD in Mental Health Mental health services	Chronic health Diabetes Muscular-skeletal pain - Arthritis Headaches / ABI Immune system Getting older Menopause Sleep/ insomnia Medications Mental health Health related cause of homeless	*"Asthma, antidepressants and arthritis".* (Woman sleeping rough in her car speaking of her main health needs) *"I am on medication, quite a lot of it… and that's helping with the pain I have…mainly due to fibromyalgia and the rheumatoid arthritis*." (Woman describing her current health needs and pain) *"I'm getting headaches* (Woman diagnosed with 3cm clot on brain , she also had her teeth knocked out by her ex-husband) *"As soon as I stopped working, I didn't realise how exhausted I had become. So, my body was starting to break down, but then when I became homeless … it worsened … it quickened again, it progressed …"I can't believe what I've been through".* (Woman whose Lupus Erythematosus contributed to her losing her job and becoming homeless and then the condition further deteriorated) *"well my health, it's gone …because I'm not doing the right thing by my tablets… I need to take my tablets three times a day, but because I'm on the streets, and haven't got my tablets, so I don't take 'em, so I just end up drinking …and I probably get sick every day".* (Woman living on the streets in the inner city) *"How would you be if that, (homelessness) happened to you, especially impacting on your mental health and then that causes stress and that causes other health problems? It can't be confined to one thing."* (Case worker) *"I have the memories and the flashback of the bashings all the time."* (Woman diagnosed with ABI) *"I've seen a variety of needs … a lot of chronic health, diabetes , unchecked or unmonitored, general chronic health conditions, a whole variety of them…mental health is a huge one. For those women that we are seeing that are homeless that are elderly or getting elderly… you can see their health needs are more acute …"* (SHSP manager)

Sub-theme	Codes	Exemplar quotes
		"The women presenting are exhausted, extremely run down and haven't had any kind of comprehensive healthcare for a long time" (nurse)
		"The women use sedation and tranquilising medications to help them sleep at night and also "to numb their anxiety, their despair, their depression … because being on the streets is often related to both mental health and drug and alcohol" (Medical practitioner)
		"Her health needs are still very secondary…health is not a priority for people who have no permanent fixed address, having to move houses, for whatever reason…they're still in that, "Where am I staying ... for the next day, week?" That's still the primary concern rather than, "Oh I've never had a Pap smear." or "My ... my knees are starting to hurt." (nurse)

Sub-theme	Codes	Exemplar quotes
Stigma, shame, embarrassment and the fear of being judged		
Previous negative experience with health system Staff understanding, attitudes, communication and non-judgemental approach Ethnic and culturally specific services	Too embarrassed about homeless situation and mental health to ask GP for help Embarrassed to tell family & friends about homeless situation Stigma of being homeless at hospitals GP pharmacist Stigma drugs Stigma of being an older woman who has become homeless Reluctant /scared ask for help Confidentiality concerns Staff judgment and understanding	*"When I became homeless, I was too embarrassed to go and see my GP because he's known me all my life and I felt like… I'm going to have to admit I actually am a failure at the moment in my life."* (Homeless woman who had slept in her car) *"People make a judgment about you …just for being homeless without any other issue".* (Woman from high socioeconomic status (SES) background) *"It's really hard when you hit rock bottom… you feel worthless, you feel ashamed… and you know, people know you, from ages ago and they see you're homeless. There is a big stigma and embarrassment about being homeless".* (Woman) *"The big barrier, untreated mental health…it's actually about protection and non-disclosure so as a service provider… in this space, the biggest barrier for us is around non-disclosure."* (SHSP manager) *"There is a lot of stigma around mental health … in the medical profession in particular towards anyone who says, "I'm on anti-depressants."* (Psychologist) *"I'd say the biggest barrier is them actually coming... presenting, isn't it? The feeling like they're too ashamed." (M*edical practitioner*)* *"I'm related to nearly all of them"* (Woman explaining why she would not use ATSI specific services as she felt *"intimidated"* and didn't want to talk with the staff there about her confidential health problems. *"Language is a HUGE barrier"* (Caseworker discussing ethnic women accessing health services)

Sub-theme	Codes	Exemplar quotes
Costs of healthcare services and pharmaceuticals		
Affordability Cost barrier Medications Access to Allied Health providers (including Dental) Access to Medical Specialists	Cost medications Access to bulk billing GP and specialists Dental Cost of getting to specialists	*"I often have up to five or six scripts at a time to get pills. Because I'm not only on the diabetes medications, Metformin and Gliclazide…there's two diabetes medications, plus I'm in Nurofen for my back. Plus, I'm on Endep to try and help me sleep. And I've been on antibiotics on and off for the last few months because of the emphysema, plus steroids."* (Woman in transitional hostel) *"Medications cost – even if it's on a script, sometimes they don't have that six dollars available" (SHSP manager)* *"There's a lot of money that goes towards medications…. And it keeps building up, every time I see my rheumatologist, there's add on, add on…"* (Woman diagnosed with Lupus which contributed to her becoming homeless) *"Even if you tell them you're homeless".* (Woman speaking of her experience of difficulties finding a Medicare bulk-billing GP) *"I am disabled …I need to catch a taxi to the specialist …but it costs"* (Woman living in short term housing unit) *"They find it difficult to budget for the future… so that they can save up for those glasses …or whatever a thing… so that becomes a factor. Cost is a barrier and, obviously, services that are free, or no cost, are going to be more attractive and enable people".* (SHSP manager) *"Women seek a dentist when they have broken a tooth or abscess "they'll just go to get that bit fixed and then they're out they won't follow up with other teeth"…"when you don't know where your next meals' coming from, your teeth are way down the list…"* (Psychologist)

Sub-theme	Codes	Exemplar quotes
Need for ongoing psychosocial and healthcare support once housed		
Older women specific needs Planning for the future Cooperation and links between providers	Vulnerable - long time Need further support while housed transitionally and beyond Social support Value access same doctor Staff help access Centrelink Staff help access longer term housing Staff help access ongoing medical Value achieving good mental health Planning for future	•"*She helps me with Homeswest… she takes me places, she'll take me to the doctors… my doctor at Balga*" (Woman in transitional housing speaking of how her case worker is supporting her to access her GP and longer term housing) •"*They come out every Monday night. They tend to be a bit proactive with me... they say, 'how are you, what's going on, are you okay?'...it's so valuable. I just… I look forward to Monday nights*" (Woman living in rented unit after years of sleeping rough – speaking of Ruah Street to Home team) •"*Every 3 months we sign little lease –so you can have a reference … so my case worker can say "she's been living here, for a year, and she's followed her lease.*" (Woman describing how she's being assisted to plan for the future and find longer term accommodation after she leaves the hostel.) *"Getting them housed and keeping them housed is huge." (SHSP manager)* *"Staff need to spend a lot of time ringing and finding up peoples Medicare details."* (Medical practitioner discussing women's lost Medicare and ID cards) *"There's a complexity of health care…. a lot of the women have long term psychiatric, psychological stresses that if you're long term in the (homeless) community that gets really reinforced …there are a lot of agendas there."* (SHSP manager) *"We're seeing women in transitional accommodation where you have more of the unravelling of long-term things, starting to come to the surface because it's been pushed down for so long, because they're just doing the survival flight or fight thing day after day, after day, after day….then once that drops away then you see all the mental health stuff come up to the surface…we find that depression can creep in and then we find that the trauma that has been suppressed for so long and comes to the surface which can be overwhelming for people."* (nurse)

Appendix M

Summary of Themes and Other Key Issues by Stakeholder Groups

Themes	Women	Specialist homelessness service providers	Health care providers
Accommodation and safety	Accommodation and feeling safe and secure were the most important factors underpinning their health.	Health is acutely affected with the risk of homelessness or being homeless. Being able to afford their accommodation places women *"in a precarious position…"* if accommodated, their health is less compromised.	Safe accommodation is fundamental to health. *"Finding a house is a base from which everything else works."*
Women's experience of trauma and abuse	Virtually all the participants had experienced some form of family violence, abuse and trauma (physical, emotional, financial). Participants spoke of the shock of not knowing what to do, who to turn to *I had a pretty protected up bringing … so I didn't know how to deal with it"*	Trauma and abuse were common underlying issues, several interviewees suggested the *extent of trauma* inflicted had a greater impact on a woman's health than the duration of her homelessness "*there's always a history of extreme trauma, or deprivation or neglect, early neglect. I mean that's probably underlying all homelessness, would be trauma …".*	*"I don't think we'd be exaggerating if upwards of 90% of people we see have some trauma that has either happened since becoming homeless, or lead them to being homeless … once you get to know them, there's all these layers… there is trauma in the background"*
Impact on a woman's health due to her inability to fulfil her role as family nurturer	Participants' relationship with their children was crucial to their health, many had been estranged from families. *"One of the things about homelessness is not having a home for my children and grandchildren"*	Providers spoke of the women's feelings of guilt and sadness about losing connection with their children and of how many of the women hid their homelessness from their children and became disconnected *"there's estrangement from family, from children and that's incredibly painful... they feel they've let their children down".*	Homelessness creates a disconnection and loss of family is a big issue… *"especially in Aboriginal older ladies, because they are supposed to be that person that is the role model…the central person to the family". W*omen from all cultures are often too embarrassed to seek help from family who may be unaware the women are ill.
Financial security	Feeling financially secure and having access to financial support was crucial to all the participant women. Having to apply for social security support was a major stressor for many women.	Extreme stress experienced by women due to financial difficulties and trying to access social security. Many of the women had lost their ID or had never previously applied for financial support.	Difficulties faced by older homeless women having to seek financial and social support and this affects their mental and physical health.

Themes	Women	Specialist homelessness service providers	Health care providers
Mental health	Many of the women had major mental health concerns which they had experienced at the outset of their homelessness experience or had developed as they spiralled into worsening living circumstances throughout their journey into homelessness.	*" the worst is mental health… the big barrier, untreated mental health"* Many older women experiencing homelessness had existing mental health concerns. Includes women's grief and loss, self-harming, the stressful impact of homelessness and menopausal problems were impacting on their mental health. Women were often in a state of shock, disbelief and abandonment.	Health providers recognised that mental health an issue for older homeless women, as well as the larger homeless population, because they have very high rates of mental health issues Alcohol is used by many of the women as a coping mechanism and use sedation and tranquilising medications *"to numb their anxiety, their despair, their depression.*
Complex physical and mental health needs	Most women said they had major mental health concerns and also multiple physical health conditions including chronic pain, insomnia and physical exhaustion. Women perceived health as "…*your physical health. Your emotional health. Your mental health. Your spiritual health. And your financial health as well"*.	Women under their care presented with a complexity of health care needs, requiring support with managing their mental and physical health needs and accessing health care providers: "*they can be very acute it's a downhill trajectory in terms of physical and mental health" …"I've seen a variety of needs … a lot of chronic health, diabetes, unchecked or unmonitored, general chronic health conditions, a whole variety of them…mental health is a huge one"* Women who were sleeping rough to women who couch surfed were marginally in better physical health.	Health Providers identified that women had multiple overlapping physical and mental health needs *"exhausted, extremely run down and haven't had any kind of comprehensive health care for a long time".* Providers observed the stress of homelessness both exacerbated and compounded mental health needs. Diabetes was commonly diagnosed. Other health conditions included injuries from falls, liver disease, and stress related gastric disorders.
Cost of healthcare services and pharmaceuticals	Women needed multiple prescribed medications to manage their physical and mental health. Many women had back pain and most women need dental and optometry services. Women said they needed free Allied Health. Virtually all said the cost of dental care is prohibitive, with long waiting lists for free services. Women said how helpful they found pharmacy staff. *Access to bulk- billing medical specialists was a problem.*	Women living on the streets have keeping their medications safe from other people, including women with diabetes and mental health problems who constantly have their medications stolen. Access to Allied Health was very limited for the women and mostly through the public health system, through Medicare. Optician and podiatry were believed to be *"virtually non-existent"* for inner city homeless people, although these services are provided at St Pats in Fremantle. Access to dental services access is difficult for many and unaffordable for most. Access to medical specialists is via health services that visit SHSP.	Older women prior to their becoming homeless unable to pay for medicines for chronic disease which further aggravated their illness. Many older women experiencing homelessness are unable to afford the gap cost of their prescribed medications. inadequate Allied Health services available to meet the needs of financially disadvantaged older homeless women. Virtually all providers stressed the need for ongoing dental care. Many women unable to afford the gap fee for medical specialists.

Themes	Women	Specialist homelessness service providers	Health care providers
Stigma, shame, embarrassment and fear of being judged	A common theme was how embarrassed, ashamed and humiliated the women felt to be homeless and how their embarrassment and fear of being judged precluded them from seeking help for their health. Many participants women felt very sensitive about being adversely judged by clinicians and health care staff and spoke about how this often prevented them from seeking healthcare. Where they perceived they had been adversely judged, this prevented them from returning for continuing care.	Women's shame and the stigma of homelessness prevents them from seeking support from SHSP, women hide the fact that they are homeless, they're dreading someone asking them about their living situation because they'll have to explain. Many had been reluctant to seek financial support from social security and needed support from SHSP with the application process. Providers said that the stigma of mental health, which was a major health barrier. Stigma and women's fear and distrust of the system and health care providers were significant barriers *"trust, confidence, the shame factor, fear".*	Stigma, women's fear and distrust of the system and health care providers were significant barriers *"trust, confidence, the shame factor, fear". The* stigma of being homeless can impact on the GP's perception of the woman. Women often too ashamed to disclose their mental health problems, especially alcohol and drug problems. Agreed that women's shame and the stigma of homelessness and are especially ashamed to admit they have a mental health condition.
Need for ongoing support once housed	Participants spoke of how staff at all of locations had helped them in a range of ways to accessing social security and accommodation, helping the women overcome their extreme anxiety about financial insecurity and housing. Women residing at short-term emergency accommodation were assisted by staff to continue accessing their own GPs in the suburbs which the women found particularly helpful. The Street to Home Program provides good follow up health care for women who have been housed.	Several providers stressed that more housing was definitely required but it had to be supported *"to reintroduce women back into society".* Providers stressed the importance of continuing to support women once they have found long-term sustainable accommodation. Once they exit the transitional hostel service *"they're kind of on their own, and all those things that contributed to their homelessness in the beginning …can make a reappearance … when you identify someone who has been quite vulnerable, you can't just put them in a house and say, "see you later" … they need some support there to continue".*	*"We're finding that the after-hours is the time when people fall apart"-* Need for ongoing support once housed was stressed and that the support needs to be at appropriate level for the woman. *"We need to let women know that "later on, when you're a bit more stable, there's somewhere you can come and have some counselling."*

Themes	Women	Specialist homelessness service providers	Health care providers
Other issues			
Complex inter-relationship of health and homelessness	Women spoke of ways in which their experience of homelessness was a complex mix of relationship and family breakdown, financial difficulties, trauma, physical health issues and mental health concerns, and many have ongoing mental health needs. Several women felt their health needs were much the same as they were before they experienced homelessness except that their ageing, combined with no stable place in which to live, was now impacting on their health and was worsening their previous health conditions.	*"It's very, very difficult to talk about anything in isolation"* … there's a complexity of health care compounded by the experience of homelessness. *"There's the grave threat of becoming homeless, the focus is on accommodation, there's a heightening of stress, anxiety, everything falls apart … and then health…. the mental health falls apart so people's well-being is acutely affected with the risk of homelessness or being homeless…the minute you've got stable accommodation the health improves.* SHSP said many homeless women had aged prematurely, attributable to trauma and a downward spiralling effect on their health once they became homeless and that the stress of homelessness further compounded the diseases of ageing, including chronic disease, poor eyesight, heart disease, dementia and osteoarthritis.	Not usually one isolated event that results in a woman becoming homeless and of how women's health needs may differ according to the stage of where they're at. *"There is no simple thing as a simple answer." W*omen can become homeless if they have chronic illness that is poorly managed, and the family can't support them, or they're dislocated from their family in some way. Sometimes a family breaks down because the health issue is too confronting. Diseases of ageing compounded by homelessness experience. Many women experiencing homelessness that are seen by doctors and nurses present much older physically than they are, presenting at 50 or 55 years come across as frail and elderly…. *"they're in the body and mind of a 70-year-old woman or 80-year-old or 90 year-old woman".*
Barriers to access/ awareness of services	Women said there was a need to raise awareness of homelessness and health services for women, and older women in particular. Women said they had been unaware of accommodation services and eventually found somewhere to live via various channels. One woman sleeping rough stressed the importance of letting homeless women know of available services.	Lack of awareness of services clearly limits women's access to health services…. *"They don't know where to go … they don't know about the services."* Women feel like they're in a "*vacuum*", have lost contact with previous providers and often all their ID documentation. Many women have to leave their own area and it is important that they are readily able to access a range of services relevant to their needs. The physical barrier of accessing Primary Health Care is exacerbated by many of the women having moved away from their health care provider.	Many in the community, including health care providers, are unaware of what services are available to women experiencing homelessness. Women's lack of awareness of health services is a barrier. If a woman has been moved from her community, if she leaves home because of violence, if she eventually finds herself in another location, she has to somehow connect with health services in that area about which she knows nothing. Suggestions to enhance/ raise GP's awareness about homelessness services – *"it's difficult, because there are a lot of GPs and there are a lot of homeless services".*

Themes	Women	Specialist homelessness service providers	Health care providers
Interagency communication , collaboration & co-ordination	Several women spoke of their frustration of not understanding where to turn for help and which services could meet their complex and inter-related social, housing and health needs. Centrelink staff visit some of the homelessness services to provide advice to homeless people although many of the participants seemed unaware of this service. One woman commented in her view *"everyone's missing the cog".* Another woman with long term illness, had just come out of hospital, said she found health services very *"disjointed".*	*"I think having clinics like the Street Doctor, like our own clinic … I think that definitely helps meet so of the needs, in terms of being responsive to meet the needs of older ladies".* The 50 Lives/ 50 Homes Project is facilitating inter agency communication and collaboration. Ruah identifies that an VISPDAT may need to be undertaken (as part of the 50 Lives 50 Homes) which is proving to be an effective means of linking homelessness and health services for highly vulnerable people experiencing homelessness. The Midland refuge spoke of the excellent relationship they have with Midland Women's Health Care. They also encourage women living in the refuge to have regular visits with their GP.	*"collaborate, collaborate, collaborate"* general agreement from providers that fragmentation and lack of coordination between services creates a gap in service delivery and results in people being lost to the healthcare services they need. For example, as women move locations, they are required to find another mental health in the next location/ area, and for women escaping domestic violence have to move location for safety and this means they have to find another GP. *"We need a coordinated approach'*
Women's specific health and homelessness needs/availability of female providers	Many women felt that being able to access and wholistic women's health services where there were female health providers who *"heard them"* had helped improve their health and preferred a female as they *"understand female problems".* Several women accessed WHFS as *"they really understand"*, especially the counselling. Where there was no female health provider, some refused to attend, especially if they had been traumatised by their male partners.	No crisis accommodation specifically for older women in Perth. Some women utilising SHS were experiencing gynaecological problems including menopause, which was a "huge" problem for these women, especially if they were living on the streets. Considered menopausal problems were impacting on the mental health and their general well-being of some of the older women utilising their services. The manager of one facility suggested an increased risk of STDs for homeless women who utilise prostitution as a means of survival.	Need emergency housing, especially for older women who may not have recently experienced DV. Women still need ongoing support with health care once housed, particularly women who have experienced trauma and abuse. Repressed memories of past trauma may emerge for some women as they age. Women sleeping rough may have menopausal and/or gynaecological problems. HHC providing some women's clinics and WHFS provides good wholistic model for women's health care.

Themes	Women	Specialist homelessness service providers	Health care providers
Staff awareness	One woman said staff needed to show more respect in the way they speak to homeless people and understand that anyone could be in this situation. Another woman said she was embarrassed she was to go to RPH Perth ED as she found the staff judgmental, and another woman told of she had been placed an ED cubicle at RPH and overheard the nurses' say *"well, she's only coming here for a bed for the night… and I thought hang on a minute, I've actually been sick. I've had a head injury. I've come in for a reason".* Women were very sensitive about being adversely judged by clinicians and health care staff and said this often prevented them from seeking healthcare or returning for continuing care. One woman refused to care after being treated disrespectfully.	A lack of health services staff understanding and judgemental attitudes, along with poor communication, were commonly cited SHSP as barriers to health care to older women, especially those with mental health issues. A lack of health services staff understanding and judgemental attitudes, along with poor communication, were commonly cited. *"The barrier is the attitude of the staff and the response".* Suggested education required for healthcare providers to facilitate understanding why women experience homelessness *"it's not a choice" "unless you walk a mile in a person's shoes, you don't know what it's like"* Previous poor experiences with the health care system was another reason for women not accessing ongoing health services. The providers noted that those women who have had a bad experience were quite reluctant to go back to that service or sometimes other services as well. Stressed the importance of creating "a non-threatening, a perceived safe environment."	Health professionals at RPH are developing an enhanced understanding of the complexity and needs of people experiencing homelessness, the attitude towards helping homeless people has changed since the introduction of the Homeless Team. Women experiencing homelessness feel judged and prefer to go to places where the staff are less judgemental of them. WHFS "*we're totally accepting of whoever you are… that it's non-judgemental…it's totally accepting here",* have received feedback from the women *"we were listened to."* *"Some of these people have had previously negative experiences in the health system. …you think about the person that's been traumatised, and (homeless) most people have, they're hyper-vigilant, so very sensitive .... and all it takes is a simple eye roll .... that's taken as rejection".*

Themes	Women	Specialist homelessness service providers	Health care providers
Culturally & linguistically appropriate services	Some of the ATSI and CALD participants considered that finding a health provider who could maintain their confidentiality was important to them. Some ATSI participants said they were a little uncomfortable going to Aboriginal culturally specific services. One woman said she was *"related to nearly all of them",* didn't want to talk with the staff there about her confidential health problems. Similar concerns expressed by some of the participants from CALD cultures who were reluctant to seek assistance from services specific to their country of birth. Especially applied to women who had experienced domestic violence as they did not feel confident about maintaining confidentiality.	Need for more multicultural services for women in suburban areas as mostly services link with multicultural services in the city. Highlighted the importance of having female providers for multi-cultural ATSI and CALD women, and the use of interpreters for communicating with women who do not speak English. Some Aboriginal women wary of accessing ATSI specific services due to their relationships with Aboriginal staff who work there …Noted the literacy problem experienced by some Aboriginal women precluded them accessing healthcare. A SHSP manager had found that that Aboriginal women had experienced so much pain and trauma, including the Stolen Generation which still impacted them,. *"for Aboriginal women, there's a lot of factors … a lot of the women we see are currently homeless, have been homeless, virtually homeless, for most of their life."*	Ethnic women experience difficulties when they become homeless as often separated from their cultural groups. If there's been Domestic Violence, they're not just leaving their relationship, they're leaving their cultural group…*"They're in another country, with another language, and different ways of being, and suddenly, they're on their own. "and their cultures can be very judgemental…. So, they're having to cut themselves off from their culture as well as their relationship"* Many Aboriginal women are reluctant to go to agencies set up for them especially, because *"everyone will know their business".*

Themes	Women	Specialist homelessness service providers	Health care providers
Arranging and attending clinical appointments	Mixed positive and negative experiences, mainly relating to how they were treated and spoken to. One women said she had some very bad experiences at RPH but the last time she was at Royal Perth ED *"I was actually pleased to see they've got a big banner up there regarding the care of the homeless now….and they've got the doctor there now. I think it's absolutely fantastic! It's about time that they've got something in the hospital to say the homeless will be cared for "We will take notice …and care for you, even if you are homeless". I was so pleased… because Royal Perth has got a bad reputation with the homeless".* St Pats provide an on site health clinic as well as access to the Street Doctor and was well utilised by older women there. St Barts ACH and also Kensington St hostel staff assist / support women to access their previous GPs in Perth suburbs which as appreciated by women interviewed at those services	The medical and hospital appointment system creates significant barriers to health care access for homeless women. This is compounded by the hospital sending appointments through the mail. *"when you are homeless, it's very difficult to get your mail… you've got no address… usually your phone is out of credit, or not charged, or you've lost it, or it's been stolen, or you've changed your number because you've lost your phone … so getting in touch with people, to follow up on appointments, hearing back from hospitals that you've got an appointment coming up soon, and understanding the paperwork that comes with that letter, very often those are huge challenges for the people we see."* General concerns from providers about older homeless women being discharged from hospitals onto the street. The DV refuge works collaboratively local health GPs and a local Psychiatrist; St Pats provide their own free health clinic run by Silver Chain with Registered Nurses. The Freo St Doctor provides an on-site Primary Care service on set days of the week with the van parked out the front of St Pats. HHC provides an in-house general practice service at some day centres and provides access and referrals to health care for women staying at night shelter.	"*Late presentations to the acute system is the norm. Ideally people with chronic conditions are best managed in primary care and for people experiencing homelessness those chronic issues never get dealt with properly, so the acute system does a great job of maintaining people in their illness … the tendency of them is to wait until they're really, really sick "and someone else calls the ambulance… and they end up in the hospital system."* appointment system provides a major gap in service delivery for people and women experiencing homelessness. The system of sending letters to no fixed address to tell people where their appointment is, and then taking them off the waiting list because they don't turn up for their appointment is a major health barrier. Primary care not the role of ED.s Value of speciality primary healthcare in sorting out some of homeless people's long-term health issues. GPs play a crucial role in facilitating access to Allied Health and Medical Specialists.

Themes	Women	Specialist homelessness service providers	Health care providers
Affordability/ cost barrier	Cost was a barrier which limited many women's access to health care. The availability of bulk billing GPs and medical specialists was raised as an issue, as was access to Allied Health services. The cost of medications was also an issue, especially if they had been prescribed numerous medications. For ATSI women, having access to "*Closing the Gap"* funding was beneficial as they were able to access to free medications. Many women who said they found it hard finding doctors who bulk bill in the city and they were "*extremely limited for choice".* The cost of transport was an issue for participants who needed to access GPs and specialists beyond the inner city.	Lost ID can be a real barrier to accessing a GP and if clients don't have a Medicare card. Many of the women had either lost or had their ID cards stolen which meant they were unable to see a doctor. Women's access to social security is also crucial for their mental health and well-being. Cost of healthcare was considered to be a barrier by several providers. Virtually all women utilised the public health system. For women who might be on a low fixed income i.e. a pension, who sought to access private providers, private insurance does not cover all costs. Travelling to health appointments also imposed financial strain on their limited resources. Access to dental services access difficult for many and unaffordable for most. Providers stressed the need for more appropriate affordable &supported accommodation in the community, to address the women's social and associated health needs of women.	All health providers interviewed agreed that cost is a *"huge barrier*" to medical services. This includes very limited access to free psychologists; whose services are not free but through Medicare bulk billing arrangements and where there is often a gap fee required. Lack of transport is a major physical barrier for older people accessing primary care services.
Impact of social determinants on health	Women came from a range of SES backgrounds, including three women who had been quite wealthy. Some of the women had been living in poverty for many years whilst others had worked and had careers. For the majority of women, their financial status deteriorated significantly as their relationships broke down, and they moved from place to place on a downhill trajectory until they became destitute.	High rate of poverty in Australia amongst the elderly is high and those people are in private rental are at considerable risk of homelessness. One SHSP stressed the potential risk for older women in poverty with complex needs to be admitted as "early entry" into residential aged care … *"so it all goes down to the issue of homelessness for older women is linked directly to poverty".* Poverty impacts on the women's capacity to afford glasses, dental care and pharmacy costs.	*"The social things that affect mental and physical health".* Parts of our culture stigmatises poverty and blame the disadvantaged, difficulties encountered by women endeavouring to access social security can enhance the shame experienced by these women … *"in* a *lot of parts of our culture poverty is still a stigma".* Suggest educating health care providers to understand homelessness is a social determinant of health, and that the cohort of homeless people has much worse health outcomes than the rest of the population.

Themes	Women	Specialist homelessness service providers	Health care providers
Survival mode and Maslow's hierarchy	The women sleeping rough were living in crisis and survival mode. Those women in short-term accommodation were still recovering from their experience of just surviving day to day and were receiving assistance to get their lives back together, stabilise and learn how to plan and look to the future.	Women's loss and inability to plan and living in chaos, and their loss of or poor coping skills all impact on their capacity to access services, to plan, to take medications. Once the women have secure accommodation, they become more stable, more future focused and they are able to make appointments and have health needs monitored	*"Women in survival mode put their health needs last…. "*

Appendix N

Participant Information Sheet for Specialist Homeless Service Providers

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

PARTICIPANT INFORMATION SHEET FOR SPECIALIST HOMELESS SERVICE PROVIDERS

Study of the Impact of Homelessness on the Health Status and Health Needs of Older Women in the Perth Metropolitan Area.

You are invited to participate in the research project described below.

What is the project about?

The purpose of this research project is to understand and document the health needs of the increasing number of older women (aged 50 and over) who are women experiencing homelessness in the Perth metropolitan area. Recent trends suggest that women over 50 represent the most rapidly growing section of the homeless population yet little is known about what their health needs are and how best to address these needs. The research is seeking to determine how health influences and is impacted by their becoming homeless; and if current health services are adequately addressing the health needs of this growing population cohort.

Who is undertaking the project?

This project is being conducted by Gloria Sutherland and will form the basis for the degree of Doctor of Philosophy (PhD) at The University of Notre Dame Australia, under the supervision of Professor Jim Codde, Associate Professor Caroline Bulsara, and Associate Professor Suzanne Robinson from Curtin University.

What will I be asked to do?

If you consent to take part in this research study, you will be asked a series of questions through a face to face interview. This interview should take approximately 60 minutes of your time, and the information will be digitally recorded.

The researcher will interview three key stakeholder groups: 1) the homeless sector providers who provide services for older women (> 50 years); 2) the health care providers currently delivering health services to older homeless women and, 3) older women who are experiencing homelessness.

Interviews with the homeless sector providers will explore their perceptions of health care needs and availability of health services for their clients, and the challenges and suggestions for the future.

Interviews with health care providers from community based, primary health and mainstream health services will explore key aspects of their perceptions of health care needs, including barriers and facilitators to the homeless population. Their suggestions to improve health care service delivery will also be sought.

Interviews with older homeless women will explore predisposing factors impacting on their health, their health care needs and health care usage including their journey into homelessness and how this has impacted on their health care needs, as well as the barriers and facilitators to health care usage.

Follow-up focus group interviews will be conducted to ensure that there is agreement on the key findings including the best model of care for older women experiencing homelessness. This should take approximately 30 minutes and will also be digitally recorded.

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Homeless sector and health care providers will be interviewed on site of their premises.

Older women participants will be interviewed in a confidential and safe and environment at either at the premises of the homeless service providers or at the relevant healthcare facility.

There are no out of pocket expenses to the participants anticipated.

Are there any risks associated with participating in this project?

There is no foreseeable risk in providers participating in this research project and confidentiality will be maintained throughout the research. All participants may withdraw from interviews at any time.

What are the benefits of the research project?

The benefits of the project are to better understand the health needs of older homeless women, especially in the Perth metropolitan area and determine whether the current services are able to meet these needs. It is important that all the key stakeholders are involved in the study as this broad consultation process will strengthen the outcomes of the study and demonstrate wide support across agencies. Acknowledging the growing number of older women who are vulnerable to becoming homeless or who are homeless, this research will enable health, housing and homelessness sector providers plan to meet their health needs.

It is anticipated that the recommendations will have implications for service delivery at the policy, planning and service delivery levels.

What if I change my mind?

Participation in this study is completely voluntary. Even if you agree to participate, you can withdraw from the study at any time without prejudice. If you withdraw, all information you have provided will be removed from the study.

Will anyone else know the results of the project?

Information gathered about you and your organisation will be held in strict confidence. This confidence will only be broken if required by law.

The results of the study will be published as a thesis and potentially a journal article, however you and your organisation will be de-identified.

Information collected and stored on audio files, written notes or computer files will be carefully secured at all times by the researcher. Data will only be accessed by the researcher.

In keeping with legal requirements, once the study is completed, all the data collected by this study will be de-identified and stored securely in the Institute of Health Sciences at The University of Notre Dame Australia for at least a period of five years. The data may be used in future research but you will not be able to be identified.

Will I be able to find out the results of the project?

Once we have analysed the information from this study we will email a summary of our findings. You can expect to receive this feedback in mid to late 2017.

Who do I contact if I have questions about the project?

If you have any questions about this project please feel free to contact either myself gloria.sutherland@nd.edu.au or my supervisor, jim.codde@nd.edu.au. My supervisor and I are happy to discuss with you any concerns you may have about this study.

What if I have a concern or complaint?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 016100F). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

How do I sign up to participate?

If you are happy to participate, please sign both copies of the consent form and keep one for yourself.

Thank you for your time. This sheet is for you to keep.

Yours sincerely,

Gloria Sutherland
PhD Candidate
School of Health Sciences
The University of Notre Dame
Fremantle WA

Appendix O

Consent Form for Specialist Homeless Service Providers

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

CONSENT FORM FOR SPECIALIST HOMELESS SERVICE PROVIDERS

Study of the Impact of Homelessness on the Health Status and Health Needs of Older Women in the Perth Metropolitan Area.

- I agree to take part in this research project.
- I have read the Information Sheet provided and been given a full explanation of the purpose of this study, the procedures involved and of what is expected of me.
- I understand that I will be asked to participate in an interview.
- I understand our conversation will be digitally recorded and that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I understand I may be asked to participate in a group discussion to provide feedback on the findings of the study.
- I agree that any research data gathered for the study may be published but my name and other identifying information is not disclosed.
- I understand that research data gathered may be used for future research but my name and other identifying information will be removed.
- I understand that I may withdraw from participating in the project at any time without prejudice.

Name of participant			
Signature of participant		Date	

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	

Appendix P

Participant Information Sheet for Healthcare Providers

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

PARTICIPANT INFORMATION SHEET FOR HEALTHCARE PROVIDERS

Study of the Impact of Homelessness on the Health Status and Health Needs of Older Women in the Perth Metropolitan Area.

You are invited to participate in the research project described below.

What is the project about?

The purpose of this research project is to understand and document the health needs of the increasing number of older women (aged 50 and over) who are women experiencing homelessness in the Perth metropolitan area. Recent trends suggest that women over 50 represent the most rapidly growing section of the homeless population yet little is known about what their health needs are and how best to address these needs. The research is seeking to determine how health influences and is impacted by their becoming homeless; and if current health services are adequately addressing the health needs of this growing population cohort.

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What will I be asked to do?

If you consent to take part in this research study, you will be asked a series of questions through a face to face interview. This interview should take approximately 60 minutes of your time, and the information will be digitally recorded.

The researcher will interview three key stakeholder groups: 1) the homeless sector providers who provide services for older women; 2) the health care providers currently delivering health services to older homeless women (>50 years) and, 3) older women who are experiencing homelessness.

Interviews with the homeless sector providers will explore their perceptions of health care needs and availability of health services for their clients, and the challenges and suggestions for the future.

Interviews with health care providers from community based, primary health and mainstream health services will explore key aspects of their perceptions of health care needs, including barriers and facilitators to the homeless population. Their suggestions to improve health care service delivery will also be sought.

Interviews with older homeless women will explore the predisposing factors impacting on their health, their health care needs and health care usage including their journey into homelessness and how this has impacted on their health care needs, as well as the barriers and facilitators to health care usage.

Follow-up focus group interviews will be conducted to ensure that there is agreement on the key findings including the best model of care for older women experiencing homelessness. This should take approximately 30 minutes and will also be digitally recorded.

Homeless sector and health care providers will be interviewed on site of their premises.

Older women participants will be interviewed in a confidential and safe and environment at either at the premises of the homeless service providers or at the relevant healthcare facility.

There are no out of pocket expenses to the participants anticipated.

Are there any risks associated with participating in this project?

There is no foreseeable risk in providers participating in this research project and confidentiality will be maintained throughout the research. All participants may withdraw from interviews at any time.

What are the benefits of the research project?

The benefits of the project are to better understand the health needs of older homeless women, especially in the Perth metropolitan area and determine whether the current services are able to meet these needs. It is important that all the key stakeholders are involved in the study as this broad consultation process will strengthen the outcomes of the study and demonstrate wide support across agencies. Acknowledging the growing number of older women who are vulnerable to becoming homeless or who are homeless, this research will enable health, housing and homelessness sector providers plan to meet their health needs.

It is anticipated that the recommendations will have implications for service delivery at the policy, planning and service delivery levels.

What if I change my mind?

Participation in this study is completely voluntary. Even if you agree to participate, you can withdraw from the study at any time without prejudice. If you withdraw, all information you have provided will be removed from the study.

Will anyone else know the results of the project?

Information gathered about your organisation will be held in strict confidence. This confidence will only be broken if required by law.

The results of the study will be published as a thesis and potentially a journal article, however you and your organisation will be de-identified.

Information collected and stored on audio files, written notes or computer files will be carefully secured at all times by the researcher. Data will only be accessed by the researcher.

In keeping with legal requirements, once the study is completed, all the data collected by this study will be de-identified and stored securely in the Institute of Health Sciences at The University of Notre Dame Australia for at least a period of five years. The data may be used in future research but you will not be able to be identified.

Will I be able to find out the results of the project?

Once we have analysed the information from this study we will email a summary of our findings. You can expect to receive this feedback in mid to late 2017.

Who do I contact if I have questions about the project?

If you have any questions about this project please feel free to contact either myself gloria.sutherland@nd.edu.au or my supervisor, jim.codde@nd.edu.au. My supervisor and I are happy to discuss with you any concerns you may have about this study.

What if I have a concern or complaint?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 016100F). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

How do I sign up to participate?

If you are happy to participate, please sign both copies of the consent form and keep one for yourself.

Thank you for your time. This sheet is for you to keep.

Yours sincerely,

Gloria Sutherland
PhD Candidate
School of Health Sciences
The University of Notre Dame
Fremantle WA

Appendix Q

Interview Guide for Specialist Homeless Service Providers

Interview Guide for Specialist Homeless Service Provider

_____

Name of Organization/ Agency

_____

Background of your (interviewee's) current role and responsibilities

_____

Today's Date

_____

Basic information about this agency

_____

Accommodation / services provided by this agency

_____

Client base

_____

1

How do women access this agency?

What are the services provided for women at this agency?

What is the process for women being able to come here to this service/ agency?

What might assist them?

What might prevent them?

The key research questions for the study are as follows:What are the health care needs of older women who are experiencing homelessness?

2. How has their experience of becoming homeless (including the contributing factors, the duration and recency of their becoming homeless), impacted on their health needs and their experience of health services?
3. What are the barriers and enablers to accessing health care for these women?
4. From the women's perspective, are their health needs being met by current service delivery?
5. From the perspective of service providers, are current services addressing the health needs of this population?
6. What are the priorities and recommendations for potential alternative services / how to improve access to health services for this population?

Q1. From your experience, what do you feel / what have you seen to be the *key health care needs of older women who are experiencing homelessness?*

Q2. In your opinion, how *has their experience of becoming homeless impacted on their health needs and their experience of health services?*

Would recency of their experiencing homelessness have an impact?

Would duration have an impact?

Impact of their living circumstances?

Would the reasons they became homeless in the first place have an impact? (eg violence, financial, health)

Q3. Considering the health issues you have seen amongst the older women experiencing homelessness who access this agency / service:

I'd like to divide this question into 2 parts – what are the *1) the barriers and what are the 2)enablers/ facilitators* to accessing health care services for these women?

Barriers

Enablers/ Facilitators

Q4. Considering the barriers and enablers / facilitators you've already mentioned, what do you feel are the reasons for these?

Impact of homelessness

Stages of homelessness

Age factor

Ethnicity

Other factors?

Q5. Are there any other issues we haven't covered that affect your clients' ability to access and utilise health care?

Q6. Let's change direction a little now so we can discuss your agency's role in supporting their clients' access to health care……..

Can you give me a recent example of an older woman you've assisted that demonstrates your agency's role in supporting their access to health care. Can we walk through the process of her accessing health care services?

Q7. In your view, are there appropriate and adequate health services to meet their needs of women using your agency?

Which health care services do you provide/ provide access to and for what purpose?

(To determine providers' perspective if current services are addressing the health needs of these women)

Q8. How accessible and effective are these services, and what are the key benefits to your clients?

Q9. Can you discuss the links between the homelessness services and the health services and how they're communicating with each other? What do you consider to be the gaps? What about specifically for older women?

(To determine the priorities and recommendations for potential alternative services/ how to improve health care for this population)

Q10. Apart from health, what other gaps are there in service delivery to meet the needs of homeless older women?

Q11 In summary, what are your suggestions for going forward / aspects to retain/ aspects to change

Q12 is there anything else you would like to add that we haven't already touched on?

Appendix R

Consent Form for Healthcare Providers

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

CONSENT FORM FOR HEALTHCARE PROVIDERS

Study of the Impact of Homelessness on the Health Status and Health Needs of Older Women in the Perth Metropolitan Area.

- I agree to take part in this research project.
- I have read the Information Sheet provided and been given a full explanation of the purpose of this study, the procedures involved and of what is expected of me.
- I understand that I will be asked to participate in an interview.
- I understand our conversation will be digitally recorded and that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I understand I may be asked to participate in a group discussion to provide feedback on the findings of the study.
- I agree that any research data gathered for the study may be published but my name and other identifying information is not disclosed.
- I understand that research data gathered may be used for future research but my name and other identifying information will be removed.
- I understand that I may withdraw from participating in the project at any time without prejudice.

Name of participant			
Signature of participant		Date	

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	

Appendix S

Interview Guide for Healthcare Providers

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Interview Guide for Health Care Provider

_____

Name of Organization/ Agency

_____

Background of your (interviewee's) current role and responsibilities

_____

Today's Date

_____

Basic information about this agency

_____

Accommodation / services provided by this agency

_____

Client base

_____

1

How do clients / women access this agency?

_____

What are the services provided for women at this agency?

The key research questions for the study are as follows:What are the health care needs of older women who are experiencing homelessness?

2. How has their experience of becoming homeless (including the contributing factors, the duration and recency of their becoming homeless), impacted on their health needs and their experience of health services?
3. What are the barriers and enablers to accessing health care for these women?
4. From the women's perspective, are their health needs being met by current service delivery?
5. From the perspective of service providers, are current services addressing the health needs of this population?
6. What are the priorities and recommendations for potential alternative services / how to improve access to health services for this population?

Q1. In your experience, what are *the key health care needs of older women who are experiencing homelessness?* (*Research question 1)*

Q2. Do you feel that the women's experiences of homelessness have impacted on their health? In what ways?

(Research question 2: How has their experience of becoming homeless (including the contributing factors, the duration and recency of their becoming homeless), impacted on their health needs and their experience of health services?)

Would recency have an impact?

Duration?

Impact of their living circumstances

The reasons that they became homeless in the first place have an impact (eg violence, financial, health)?

Q3. Based on your knowledge and experience of your clients, what would have your found to be their experience of health services?

What would you say are the main barriers and facilitators / enablers to their accessing health care services? *(Research question 3: What are the barriers and enablers to healthcare for this population?)*

Barriers

Enablers/ Facilitators

Q4. From your perspective, are there appropriate and adequate health services to meet their needs?

Which health care services are provided and utilised and for what purpose?

How accessible and effective are these health services in relation to the needs of these clients? Some of the key benefits? *(Research question 5: From the perspective of the **Providers**, are current services addressing the health needs of this population?)*

Q5. What do you consider to be the main benefits/ impact of YOUR (health related) service?

Q6. Apart from the delivery of health services, from your experience and understanding, are there any gaps in service delivery to meet the needs of homeless women in the Perth metropolitan area?-

What and where are these gaps?

Q7. From your perspective and experience, how effective is the coordination / and communication between the various homeless sector agencies and health agencies?

Some good examples?

Some not so good?

Q8. Can we discuss the links and gaps between the a) health services and b) also between the health services and the homeless services:

What do you consider are the links?

What do you consider to be the gaps?

(Research question 6- What are the priorities and recommendations for potential alternative services / how to improve access to health care services for this population?)

a) **Health services - links and gaps**

b) **Health and homeless services – links and gaps**

Q9 Specifically for older homeless women, what and where are the gaps in service delivery?

(What are the priorities and recommendations for potential alternative services / how to improve access to health care services for this population?)

Q10 Suggestions for going forward / aspects to retain/ aspects to change

Q11 is there anything else you would like to add that we haven't already touched on?

Thank you.

Appendix T

Email Invitation from Researcher to Participate in Delphi Panel Survey

Study of the Health Needs of Older Women Experiencing Homelessness

Dear xx

As you may be aware, for the past 3 years I have been leading a research project investigating the health needs of the growing cohort of older women who are experiencing homelessness in our community.

I am now seeking your input into this crucial stage of our research, given your comprehensive experience and knowledge in the area of older women's homelessness.

To date, the primary purpose of our study has been to engage, quantify and document a comprehensive account of the health needs of older women experiencing homelessness, and determine if current health services are able to adequately address the immediate and future health needs of the increasing population cohort of older women experiencing homelessness in the Perth metropolitan area. The first two phases of the study utilised surveys and interviews with women, as well as interviews with homelessness service providers and healthcare providers. Data from these phases has been analysed and categorised into themes, from which a series of recommended strategies and actions have been developed. In this final phase of the project, we need your insights to help confirm and prioritise these recommendations that are aimed at improving the access and configuration of healthcare services for older homeless women.

Summary information from phases one and two is provided as background to a short survey about the recommendations. The link below will take you to the background information and the survey, which should take less than 15 minutes to complete. Please note, responses to the survey must be completed by Friday 24th May.

https://forms.gle/hkMr2QNQvUbSQC9R7

We greatly appreciate your expert input to this important work. Please note that all individual information will be kept confidential and only aggregated information will be released from this study.

Yours sincerely

Gloria Sutherland
PhD Candidate

Professor Jim Codde
Associate Professor Caroline Bulsara
Professor Suzanne Robinson
Institute for Health Research

Appendix U

Background Study Information for Delphi Panel

Health needs of older women experiencing homelessness in the Perth metropolitan area

This document provides information that should be read before responding to the survey.

This is the final stage in a study that seeks to explore the health needs and accessibility of healthcare services for older homeless women living in the Perth metropolitan area. Drawing on detailed survey data and face-to-face interviews with 22 older women experiencing homelessness, combined with input from specialist homelessness services and health care providers, the responses were categorised into nine themes that reflected their experiences and circumstances. These themes have been grouped into three broad categories to help define potential strategies/actions to address the underlying issues.

Drawing on this information and your own experiences, I seek your views on a range of recommendations designed to address the health concerns of these women.

Contextual issues

Theme 1: *Accommodation and safety*

Survey data: The majority of women (73%) were living in medium term/ transitional housing at the time of survey, but prior to this had lived in a range of places including 23% who had no shelter nor accommodation (living on the streets), 9% had slept in cars and 9% had stayed in crisis (mixed sex) accommodation. Many of the women (36%) were experiencing homelessness for the first time and had been homeless for less than one year, whilst 64% had been homeless between 1-10 years. Over half the women (59%) had been victims of violence or aggression during the time they had been homeless.

Interview data: All the women reported that their health had been, and remained, affected by their experience of homelessness and that being accommodated and feeling safe were the most important factors underpinning their health. They also expressed that they were initially unaware of how to locate housing and support services when they first became homeless which greatly added to their stress.

Providers also reported that lack of safe accommodation acutely affected the women's health and placed the women in a precarious position and at risk of violence. They mentioned the lack of emergency accommodation in Perth for older women was of concern and that health care providers needed to be fully informed of the availability of homeless services so they could help the women access these services as soon as possible.

Theme 2: *Women's experience of trauma and abuse*.

Survey data: Women's past experience of violence and trauma was significant with 81% experiencing family violence, including physical and emotional abuse. 86% of women reported having injuries and trauma as their most common health concerns with 18% women still having residual Acquired Brain Injury (ABI) from beatings from their former male partners

Interview data: Many women reported that family violence directly contributed to their mental and physical health. Women who had experienced abuse from their male partners reported being afraid or reluctant to see male providers and sought female health care providers including doctors, nurses, psychologists.
Providers said that trauma and abuse were common underlying health issues for women, and that the length of the time and the extent of the trauma had a significant impact on the woman's health.

Theme 3: ***Impact on a woman's health due to her inability to fulfil her role as family nurturer***
Survey data: The women's relationship with their children and their families had a significant impact on their health. Over half of the women interviewed had regained their relationship with their children and 32% were 'close to' their family through the assistance of homelessness and community services. Connection with family was particularly important to the Aboriginal women (32% women interviewed), most of whom said they were in contact with their extended families.
Interview data: Women said their relationship with their children was crucial to their health and many had become estranged from families due to their homelessness experience.
Providers reported that homelessness creates a disconnection and loss of family is a major painful issue for these women and often these women were too embarrassed to ask their families for assistance and hid their homelessness and health needs from their families.

Theme 4: ***Financial Security***
Interview data: Feeling financially secure and having access to financial support was crucial to all the women. Having to apply for Centrelink benefits was a major source of stress.
Providers noted the extreme stress caused due to financial difficulties, with many of the women never having to seek financial support before. The providers also commentated that financial insecurity affected the women's mental and physical health.

Healthcare needs

Theme 5: ***Mental Health***
Survey data: Half the women indicated they had mental health concerns, with almost three quarters saying they had suffered from or were currently experiencing depression. Sleeping problems and fatigue were experienced by 73% women.
Interview data: Many of the women reported experiencing major mental health concerns from the outset of their homelessness that deteriorated further as they spiralled into worsening circumstances. They described numerous barriers to accessing mental health services including stigma, and trust issues because of their previous bad experience with mental health service, financial limitations and systemic barriers. The lack of a female provider was identified as barrier, especially female psychologists and psychiatrists.

Providers considered mental illness to be a major health need for older women experiencing homelessness. Several suggested this may be related to the chronic trauma and/or from domestic violence they experienced.

Theme 6: *Complex interaction of physical and mental health needs*
Survey data: The majority women (91%) reported having a complex mix of both mental health and physical health needs with one woman saying she had extreme injuries (ABI) from a beating. For 86% women, their most common health need related to injury and trauma, 73% experienced depression, 50% women had ongoing mental health concerns, 73% were suffering from fatigue and exhaustion.
Interview data: During the interview, most women confided that they had major mental health concerns aggravated by multiple physical health conditions including exhaustion, insomnia and pain.
Providers reported that the women needed significant support to manage their complex health needs, and the multiple, chronic and co-existing health issues were exacerbated their homelessness situation. They also stated that women tended to neglect their health needs and often presented late to the acute health system.

Barriers to access

Theme 7: *Costs of healthcare services and pharmaceuticals*
Survey data: For 76% women, their most common health services utilised since becoming homeless was a GP/doctor. This included 32% women identifying they had utilised a mobile GP/ Street Doctor. 55% women had utilised psychological counselling where available. Many reported a range of ongoing health issues that were unresolved. For example, 73% reported having dental problems and 82% had conditions of the ears, eyes, nose and throat. These conditions included hearing difficulties, ear infections, tinnitus & vertigo (from physical assault), poor vision and/or inadequate spectacles.
Interview data: Lack of bulk billing GPs, medical specialists and allied health services was raised constantly by the women. Allied health services were generally cost prohibitive except in a few cases where they were able to access some level of financial support or a free service. Similarly, access to non-Medicare funded healthcare such as dental and psychology services were unaffordable for most. Many women also reported that the cost of medications was an issue, especially when prescribed numerous medications.
Providers agreed that costs associated with healthcare was a barrier for the women. Optical, dentistry and podiatry services were believed to be "virtually non-existent" for inner city homeless people. While some homeless support services provide some healthcare services on-site, this was limited due to the costs and the inadequacy of available funding to ensure that existing programs remain sustainable.

Theme 8: *Stigma, shame, embarrassment and the fear of being judged*
Interview data: The women reported often being embarrassed, ashamed and in-fear of being judged when seeking health care. Many of the women found medical and nursing

staff to be judgemental and disrespectful although others reported a much more positive experience. The women were especially embarrassed and ashamed to admit to their GP that they had a mental health problem.
Similarly, providers cited that a lack of staff understanding, along with poor communication, created barriers to health care for older women, especially those with mental health issues. They also felt that shame and stigma of homelessness prevented the women from seeking health care. Health care providers had observed that the stigma of being homeless can impact on some GPs' perceptions of the women.

Theme 9: ***Need for ongoing support (including psychosocial and healthcare support) once housed***
Survey data: Women's homelessness status ranged from >3 months to <10 years, with 36% women experiencing homelessness for 1 – 5 years. Overall, 59% women interviewed said their current health had not changed over the past 12 months, and no women experiencing homelessness for up to 12 months felt their health had improved over the past 12 months.
Interview data: All of the interviewed strongly expressed their need for ongoing health and psychological support. The women spoke of how staff at the homelessness services had helped and were continuing to help them access social security, health care and more permanent accommodation.
Homeless service providers expressed the importance of continuing to support women once they have found accommodation due to the women's need for ongoing assistance and counselling. They indicated that the older women remained vulnerable for some time after being housed as factors that contributed to their homelessness tended re-emerge.

Appendix V

Delphi Panel Web-Based Google Forms Survey

EXPERT PANEL REVIEW

* Required

Study of the Health Needs of Older Women Experiencing Homelessness in Perth

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Thank you for agreeing to complete the survey below. The purpose of the survey is to gain your opinion on how to best inform the policies and practice of providing healthcare to older women experiencing homelessness in our community. A summary of the current findings is available to help inform your choices and is accessible via the link below. Please read the document from the link below before completing the following survey. Please note, all information provided will be treated anonymously and no aspect of your responses will be attributed to either you or your organisation.

A summary of the current findings (background information) is available to help inform your choices via the following link:
https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3A75b500cf-7501-47f7-9d91-9b3b98609f1c

Please indicate which category is most relevant to you.

- ◯ Work in an organisation that provides support to people experiencing homelessness
- ◯ Healthcare provider
- ◯ I have been, or currently am, an older women experiencing homelessness
- ◯ Other: _____

Information obtained from the women, homelessness support and healthcare providers was collapsed into the nine themes as listed in the background information document. From these, a series of recommended strategies and actions have been developed, and for which I seek your thoughts.

These recommendations are as follows:

1. Priority access to safe accommodation be provided to older women experiencing homelessness to meet their immediate and ongoing health needs.

2. Strategies be developed to raise awareness of services provided to support the homeless, especially those for older women.

3. Educational opportunities be created to raise the understanding of healthcare providers of the complexity of women's need to re-connect and maintain their relationship with their children and family.

4. Provision of funding to enable homelessness services to provide or refer clients to psychosocial and healthcare support from the initial stages of their homelessness and after they access accommodation.

5. Due to the high level of physical, psychological and sexual abuse experienced by many homeless women, healthcare services should provide an option to access to female GPs, nurses, allied health and psychological service staff.

6. Primary healthcare services supporting older homeless women should be integrated with mental and allied healthcare, including priority referrals to dental care.

7. Special care services that are safe, secure and easily accessible be designed and resourced to meet the complex health needs and impact of trauma on mental and physical health of homeless women should be established.

8. Educational opportunities be created to educate healthcare providers of the importance of early identification of older women experiencing homelessness to facilitate early intervention in terms of housing and healthcare.

9. The emotional needs of homeless women should not be neglected when planning for appropriate healthcare services including feelings of shame, embarrassment, loss of role as a family nurturer, grief and estrangement from family.

From the above recommendations, please use the scroll bar below to identify your TOP FOUR priorities (in order of importance) to address the healthcare needs of older women experiencing homelessness. *

	1. Safe accommodation	2. Awareness raising of services	3. Education re family reconnection need	4. Fund homelessness services to incl psychosocial & health support	5. Women's access to female healthcare providers	6. Integrate primary care to incl mental & allied health
Priority #1	○	○	○	○	○	○
Priority #2	○	○	○	○	○	○
Priority #3	○	○	○	○	○	○
Priority #4	○	○	○	○	○	○

Please provide a brief explanation regarding your choice for Priority #1.

Your answer

Based on the information collected from this study and your own knowledge and experience regarding women experiencing homelessness, is there ANOTHER recommendation that you would suggest that is not listed above? If YES, please provide a brief explanation. (If NO, please proceed to the next question).

Your answer

Do you have any further comments you wish to contribute towards the identified themes or recommendations of this study?

Your answer

We greatly appreciate your completing this survey. The information will be kept confidential and individual responses will not be identified in any report. Your input will be very valuable in determining the final recommendations for this research project.

Gloria Sutherland (PhD candidate)
Supervisory team: Professor Jim Codde, Associate Professor Caroline Bulsara and Professor Suzanne Robinson

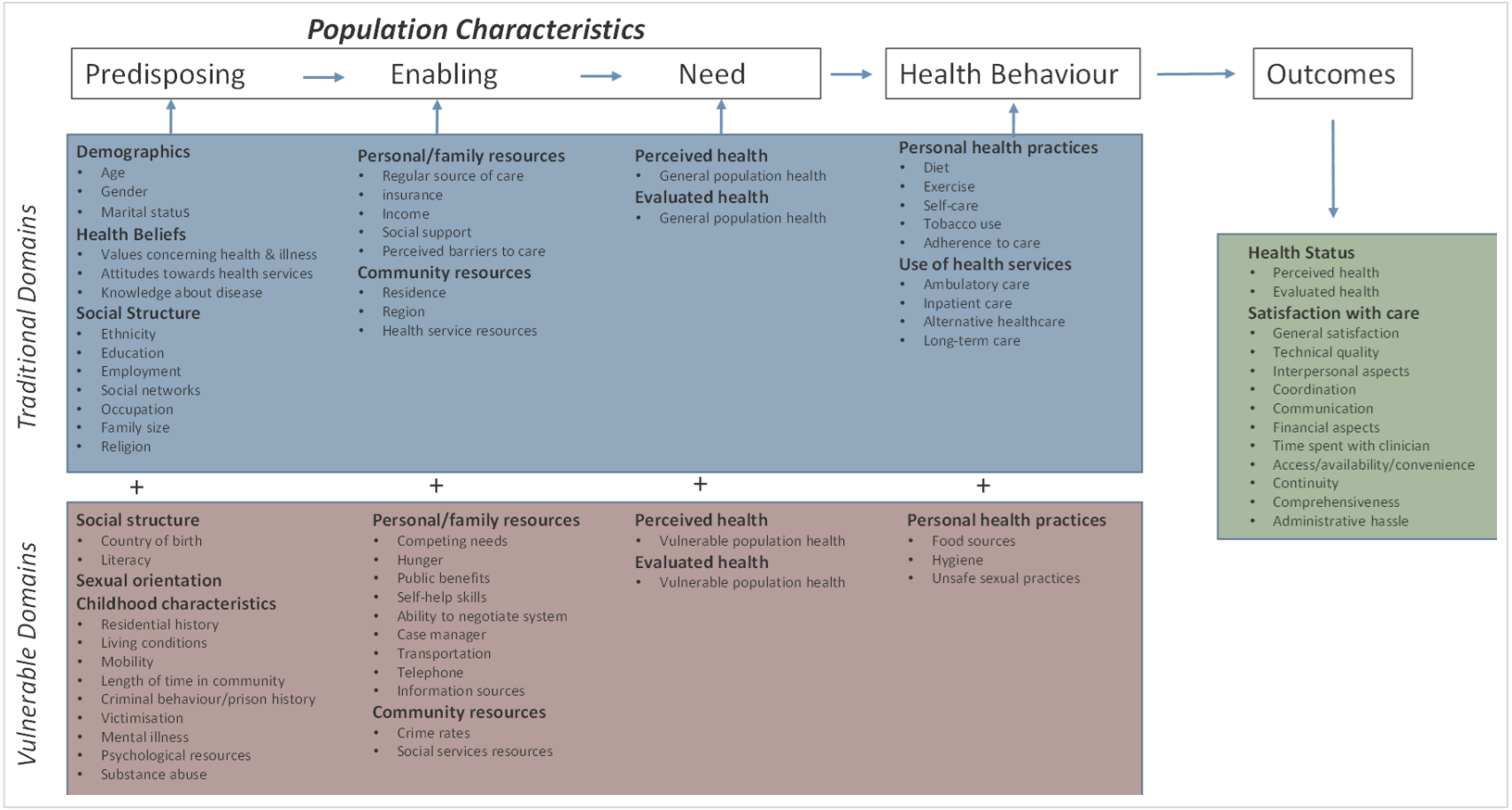
If you would like to be kept informed about this project, please add your name and email address for my records.

Your answer

Submit

Appendix W

Behavioural Model for Vulnerable Populations



Source: Gelberg et al., 2000